



THE CITY OF SAN DIEGO

FLEXIBLE BENEFITS PLAN

Summary Highlights
2009 – 2010

TABLE OF CONTENTS

FLEXIBILITY	3
How Your Flexible Benefits Plan Works	
ELIGIBILITY	4
Participation in Your Flexible Benefits Plan	
ENROLLMENT	6
Choosing Your Benefits	
LIFE INSURANCE	8
Important Coverage to Protect Your Family	
MEDICAL BENEFITS	9
Flexible Benefits Let You Choose	
MEDICAL PLANS AT A GLANCE	12
DENTAL BENEFITS	18
Dental Insurance for You and Your Dependents	
VISION BENEFITS	22
Optional Coverage for You and Your Dependents' Eye Care	
REIMBURSEMENT ACCOUNTS	24
Additional Ways to Plan and Save Through Flexible Benefits	
DENTAL/MEDICAL/VISION REIMBURSEMENT	27
A Tax-Free Way to Pay for Additional Expenses	
DEPENDENT/CHILD CARE REIMBURSEMENT	31
Taking Care of Those in Your Care	
401(K) PLAN	34
A 401(k) Plan Can Be Coordinated with Flexible Benefits	
CASH PAYMENT	36
Taxable Benefit	
CONTINUATION OF COVERAGE	37
How to Continue Your Medical Coverage	
NOTICE OF PRIVACY PRACTICES	41
NOTICE OF MEDICARE AND PRESCRIPTION DRUG COVERAGE	43
ADDITIONAL INFORMATION	45
Facts You Should Know About Your Plan	

continued next page

APPENDICES

A: Flexible Benefit Allotments46

B: Annual Values of Medical Benefit Plans 47

C: Basic/Supplemental/Additional Life Insurance Premiums48

D: Dental and Vision Annual Values50

E: Frequently Asked Questions 51

F: Allowable Medical Expenses53

G: Questions and Answers About Your Flexible Benefits 55
and Reimbursement Accounts

H: Comparisons Between the City of San Diego 401(k) and Deferred Compensation Plans56

I: Provider Telephone Numbers57

IMPORTANT: This handbook contains brief descriptions of all the benefit options covered under the Flexible Benefits Plan program. Please keep in mind that this material is a summary of legal plan documents. Should there be a disagreement between this handbook and the legal plan documents governing the program, the legal plan documents will control.

Information regarding your benefit options are available in other forms of communications for visually and/or hearing impaired employees. Contact Flexible Benefits at (619) 236-5924 for more details.

FLEXIBILITY

HOW YOUR FLEXIBLE BENEFITS PLAN WORKS

Can I Pick as Many Benefits as I Want?

Your Flexible Benefits Plan Worksheet lists all the benefit options available to you. Every insurance benefit option has a cost which is called the annual value. You can pick as many benefits as you want. If you exceed the Flexible Benefits Annual Allotment the difference will be deducted from your biweekly paycheck.

Annual Allotment

The FY 2010 Flexible Benefits annual allotment will differ by your represented bargaining unit and in some cases by the level of medical coverage that you elect. The FY 2010 Flexible Benefits Plan will start on July 1, 2009 and end on June 30, 2010 for all eligible employees working or in a benefited status on pay period ending July 10, 2009.

The FY 2010 allotments are shown on page 46 in Appendix A.

How Are Your Benefits Paid?

The full value of the benefit allotment is not available at the beginning of the fiscal year or the date you were hired if you are a new employee. You earn a portion of the allotment each pay period throughout the fiscal year.

For your benefits to be paid, you have to be in a benefited status each pay period. If not, the premiums for life, medical, dental, and/or vision are not paid. If you have dental/medical/vision reimbursement, dependent child care reimbursement, 401(k) and/or cash payment, the biweekly contribution is not posted to your account. Therefore, the amount you will receive for the reimbursement options will be less than the amount you allotted for the fiscal year. New employees become eligible the first pay period you work 40 hours.

How to Calculate the Bimonthly Amount

To determine how much the payroll deduction will be for each benefit you select, subtract the Flex biweekly allotment of each benefit choice from the cost. This is how much the payroll deduction will be for your and your dependents' medical insurance. By taking this deduction on a pre-tax basis your paycheck will not be reduced by the full amount because of the tax advantage of pre-tax deductions. For more explanation on this concept see the Reimbursement Account section of this booklet.

ELIGIBILITY

PARTICIPATION IN YOUR FLEXIBLE BENEFITS PLAN

Who Gets the Flexible Benefits Plan?

You are considered an eligible employee if you are:

- directly employed by the City of San Diego, and
- working in a 1/2 time (40), 3/4 time (60), or full-time (80) benefit status.

NOTE: Hourly employees are not eligible for this plan.

What Does Benefitted Status Mean?

This means that you were hired in a position that receives benefits and are in a “paid” status for at least **40 hours** per pay period.

If you are not working due to the reasons listed below, you are considered to be in a benefitted status. The City will continue to pay for all or for certain benefits as required by law or City policy. You are responsible for any payroll deductions.

- Annual/Sick Leave (minimum 40 hours/pay period)
- Long-Term Disability (1 year)
- Family Medical Leave (FMLA) – 12 weeks maximum (except 26 weeks maximum in the case of care of an injured serviceperson)
- Industrial Leave* – 2080 hours maximum
- Total Temporary Disability (TTD)* – 2080 hours maximum
- In-house Vocational Rehabilitation (VRMA)* – 2080 hours maximum
- Military Leave – 30 day or presidential military leave
- Mandatory and/or Voluntary Furlough

**combined total for all three*

What Happens if I Stop Working or Work Less than 40 Hours?

If you are an eligible employee and you worked less than 40 hours for any reason (other than those specified above), then your benefits will stop. The City does not pay for your benefits if you do not work or work less than 40 hours a pay period excepting furlough. However, you may continue your life and medical coverage (and certain other optional benefits) at your own cost until you return to benefitted status

for up to eighteen months. You may convert your basic life insurance to an individual policy and continue directly with the insurance company.

If you do not pay your premiums, coverage will stop for you and your family. When you return to benefitted status, all your benefits will resume on the first of the month the full cost of insurance has been paid.

If you continue your coverage, but do not continue your dependents, you will not be able to add them back to your plan upon your return to benefitted status but instead will need to wait until the next open enrollment period.

If your absence qualifies under the Family Medical Leave Act (FMLA) or California Family Rights Act (CFRA) and you are eligible, you are entitled to City paid medical insurance for up to twelve weeks in a one year period (combined between both FMLA and CFRA). A special 26-week FMLA leave may also be available to care for an injured service person. To be eligible for FMLA you must have been employed for the City for at least twelve months and have worked for the City at least 1,040 hours in the 12 month period and you must be on leave for your own serious medical condition, the birth or placement of your child within 12 months of occurrence, to care for an eligible family member with a serious medical condition, or to deal with a military exigency involving a family member who is called to active duty. You must submit a Family and Medical Leave Certification form signed by a physician to initiate your request. For more information on FMLA, eligibility and qualified absences contact your department payroll specialist and request the initial notice dated February 1994.

What Happens if I Terminate and Get Rehired Within the Same Fiscal (Plan) Year?

If you terminate employment and are rehired within the same Plan year, your benefits prior to your termination will be reinstated. Unless you have a change in status, you will not be allowed to change your benefits until the next open enrollment period.

If you have further questions about stopping or returning to work, call the City's Flexible Benefits Plan Section at (619) 236-5924.

Change in Status

Federal law requires that once you have chosen your benefits and the Plan Year begins, they will stay in effect until the Plan Year ends. This includes the amount you contribute to your Reimbursement Accounts. However, if you have a change in status that affects your benefit needs, you may be able to change your benefit selections before the end of the Plan Year. Changes must be reflective of your status change. If you are in a classification represented by MEA or Local 127, should you gain other medical coverage during the year you are not eligible to select the waiver option until the following open enrollment period. Changes to (increase or decrease) Dental/Medical/Vision Reimbursement are not allowed.

A change in status includes but isn't limited to:

- marriage
- divorce, legal separation or annulment
- birth or adoption of a child
- death of a spouse or dependent
- your spouse or dependent becoming eligible or ineligible
- for medical insurance coverage
- your spouse or dependent starting or ending employment
- court order
- change in residence or work site that changes your eligibility for an HMO or other plan

Addition and deletion of dependents from your medical, dental or vision plan is not automatic. Notification to or from the carriers, including temporary membership cards for newborns, does not constitute a change in dependent coverage. It is your responsibility to notify the Employee Benefits section of any change in dependent status, whether or not it affects your premiums. No retroactive benefits or reimbursements will be provided.

You must submit your written request to change your benefits with applicable insurance enrollment/change forms and supporting documents (birth certificate, marriage certificate, proof of coverage or COBRA termination letter) within thirty (30) days of the change in status to Flexible Benefits Plan Section, MS 51E. If after thirty days, the change must wait until the next open enrollment period, which could result in a loss of certain benefits.

Domestic Partner Eligibility

Benefit coverage is extended to domestic partners for many of the benefit options. A notarized affidavit attesting to a qualified domestic partner relationship must be completed in order to cover the domestic partner as an eligible dependent. This requirement is waived if you and your domestic partner have registered with the State of California or have another legally binding commitment. In this case you need to provide proof of domestic partner registration.

NOTE: It is against IRS regulations to pay for coverage for a domestic partner with pre-tax dollars unless they are a dependent as defined by Section 152 of the Internal Revenue Code. For this reason, in order to use your Flexible Benefits allotment or use pre-tax payroll deduction for your domestic partner, a notarized Affidavit of Domestic Partnership (even if registered) and a copy of your most recent income tax return must be provided to Risk Management. If you are enrolling your non-dependent domestic partner under your medical plan, you must pay for that coverage through post-tax payroll deduction only. For dental and/or vision insurance you can also pay for this coverage via post-tax payroll deduction.

ENROLLMENT

CHOOSING YOUR BENEFITS

Selecting and Registering Your Choice During Open Enrollment

As an eligible benefited employee, you must enroll for your benefits through EASY ENROLL, the City's automated touchtone telephone enrollment system during the designated open enrollment period.

To do so, you are assigned a protected personal identification number (PIN) and are asked to enter this number before enrollment can begin. Be sure to keep your PIN number confidential to ensure your benefit enrollment is secure.

If you forget your PIN number, you can call EASY ENROLL and follow the prompts to reset your PIN.

Using EASY ENROLL

EASY ENROLL is very easy to use. Don't worry if you make a mistake or didn't hear something:

- EASY ENROLL lets you review your choices at the end of the telephone call before confirming your choices.
- EASY ENROLL allows you to change your choices, so you can make a new selection, before confirming your benefits.
- You may leave EASY ENROLL at any time by hanging up.

You enroll for your benefits with EASY ENROLL by using the keypad of numbers (0 – 9) on your telephone. The voice on the EASY ENROLL telephone line will tell you which number to press on the telephone to keep your same benefit or to make a change.

At certain times during the telephone call, you will be asked to press the "pound sign". The pound sign is the button in the lower right corner of the numbers on the telephone key pad with the "#" on it.

When you choose how much you want to set aside of flexible benefit dollars or from your paycheck, you will enter the amount for the full plan year in whole dollars. This means that you do not enter "cents". For example, if you want to set aside \$1,000 for 401(k) for the year you would press: 1000#

EASY ENROLL will tell you how much will be deducted from your paycheck each pay period, if any, for your benefit choices. Any required payroll deductions, as determined by your enrollment through EASY ENROLL, will become effective the pay period ending 7/10/2009 with the exception of portable life insurance which becomes effective the pay period following approval by the insurance company.

You will receive a confirmation statement within 2 to 3 days after you have successfully enrolled. Be sure to review it carefully. If you find that you made a mistake or you change your mind, you may re-enroll through the last day of open enrollment. After this date, your benefit elections are final.

To use the EASY ENROLL telephone line, follow these steps:

1. Use a push-button phone that uses the "tone" mode (not a rotary dial phone) to make your call. It is not recommended that you call using a cellular phone. If you don't have a push-button wired phone at home, contact your payroll specialist or Flexible Benefits Plan Section at (619) 236-5924.
2. Be sure to complete your enrollment worksheet before calling. Have the worksheet in front of you when you call.
3. Call (619) 236-7373 or on the City's phone system 67373.
4. Follow the instructions given through EASY ENROLL. Listen carefully to avoid any mistakes.
5. At the end of the call, be sure to confirm your elections by pressing #1. Upon confirming your elections you will hear: You have successfully enrolled. Thank You. Until you hear this, you have not completed your enrollment.

Help with Enrolling

If you need assistance, or have a hearing/vision limitation, contact Flexible Benefits Plan Section at (619) 236-5924 or your payroll specialist.

Completing the Enrollment Process

After you receive your confirmation statement, complete all necessary forms. Your confirmation statement will show you if an application is needed. If you are keeping your same health insurance but adding or deleting a dependent(s), you must complete the necessary form available on the intranet – Employee Benefits link or your payroll specialist. If you are enrolling for a plan for the first time, you must complete an application form. It is very important that these forms be completed and submitted to Employee Benefits before July 1, 2009.

NOTE: If you are enrolling dependents and do not complete the required enrollment form prior to when the coverage is set to begin, your coverage will be changed to Employee Only. The flexible benefit dollars for this coverage will be placed in the Cash Payment option (if MEA or Local 127 represented) or reduced to the Employee Only allotment for all other employees. You will not be allowed to enroll your dependents until the next open enrollment period.

If You Don't Enroll

Federal law requires you to enroll for your benefits before the start of the Plan Year (July 1st) so that the benefits may be offered to you free of taxes. For this reason, if you do not complete enrollment within the open enrollment period, your current benefits (or comparable plan if your current plan is no longer available) including any dependent coverage and optional benefits such as reimbursement and 401(k) contributions will be continued as if you had elected to keep them. If the cost of your benefits exceed the allotment, the difference will be deducted from your paycheck. Payroll deductions for portable term life, dental/medical/vision reimbursement, dependent/child care reimbursement and/or 401(k) will continue.

If You Are a New Employee

As a new employee, you are required to attend the New Employee Orientation (NEO) to complete the Flexible Benefits Worksheet and applicable paperwork. Risk Management will collect the Flexible Benefits Worksheet and necessary application forms to process your enrollment on the Flexible Benefits system at the end of the orientation. You will receive a copy of your paperwork with the effective date and pro-rated value of your benefits selections indicated on the Flexible Benefits Worksheet once your paperwork has been processed. You will enroll through EASY ENROLL for future open enrollments.

Dependents can only be added during open enrollment or when an employee becomes eligible for benefits unless there is a change in status event as described on page 5.

The annual allotment will be prorated based on the date you first become eligible for benefits. However, when choosing your benefits use the full value and Benefits staff will prorate the amount for you.

NOTE: For those options selected whereby a labor organization administers the benefit, payments will be made by Risk Management directly to the labor organization on your behalf.

LIFE INSURANCE

IMPORTANT COVERAGE TO PROTECT YOUR FAMILY

When Your Coverage Begins

For Fiscal Year 2010, your coverage will begin on July 1, 2009.

If you are a new employee or have elected a new life insurance amount, your coverage or new amount will start the first of the month following when you physically report to the work site after July 1 of the benefit year.

When Your Coverage Ends

For Fiscal Year 2010, your coverage will end on June 30, 2010.

If you leave your job with the City before the fiscal year ends (June 30, 2010) your coverage will end on the last day of the month in which you leave. Contact Flexible Benefits Plan Section at (619) 236-5924 if interested in continuing your policies upon termination.

If you are on an approved "Leave Without Pay" status, you may be eligible to continue your coverage by paying the required premium. Flexible Benefits staff will send you a letter asking if you want to continue your coverage. If you don't continue, your coverage will stop on the last day of the month in which you worked or don't pay your required premium.

What Kind of Coverage is Available

If you are represented by MEA or Local 127 you have a choice of three levels of Basic term insurance – \$10,000, \$25,000, \$50,000. You must select one of these options and pay for it from your Flexible Benefits allotment. The annual cost for each amount is shown in Appendix B.

If you are represented by POA, Local 145, DCAA or are Unrepresented or Unclassified you will receive \$50,000 of Basic term insurance at no cost to you.

The Basic term insurance includes Accidental and Dismemberment Insurance (AD&D). In case you die or are injured permanently, the policy may pay up to the amount of your Basic life insurance amount. An accelerated benefit is also available that provides up to half of the policy amount at the time you are diagnosed with a terminal illness.

Additional Life Insurance Available To You and Your Dependents

Portable term insurance allows for continuation of the policy at the City's group rates at time of termination up to age 70. At age 70 you can convert to an individual policy. There are various levels of coverage from which to choose. You may increase the amount of portable coverage by one level without having to submit proof of good medical.

Your spouse or domestic partner can also obtain a policy under this portable term plan. Your children can be enrolled for a limited policy if either you or your spouse/domestic partner are enrolled. The levels and the premium rates are shown in Appendix C.

Refer to the Life Insurance brochure from your department's payroll specialist for more details on your life insurance benefits.

A Word About Beneficiaries

A beneficiary is the person who you name to receive your life insurance amount if you die. You may change your beneficiary at any time by simply submitting a new life insurance enrollment form to the Employee Benefits Division of the Risk Management Department. It is to your advantage to keep the beneficiary you name current. For example, if you get married, divorced, or the person you name as beneficiary dies, you may want/need to change your beneficiary.

MEDICAL BENEFITS

FLEXIBLE BENEFITS LETS YOU CHOOSE

What Kind of Coverage is Available

The medical insurance you are eligible to select is listed on your Flexible Benefits Worksheet.

For MEA you must be in a classification represented by MEA but you do not need to be a member of the labor organization in order to select its medical plan.

The chart on the next few pages describes the often used services of the medical plans offered through the City's Flexible Benefits Plan. The benefits described on the Medical Plans at a Glance are only an overview. To find out about specific coverages, please request a brochure from your department's payroll specialist. For information on what brochures are available and how to order them, see page 45.

Important Notice About Your Rights Under Your Group Medical Plan

Your medical plan provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema) as required by the Women's Health and Cancer Rights Act of 1998. Call your medical plan or Flexible Benefits at (619) 236-5924 for more information.

If you or a family member are eligible for Medicare, please refer to the notice on pages 43 – 44 regarding prescription drug coverage.

When Your Coverage Begins

All of the medical plans are prepaid plans. Prepaid means that the payment for the current month pays for the following month.

Based on this, for Fiscal Year 2010 your coverage will begin on August 1, 2009 because the payment in July pays for August coverage.

If you are a new employee, you and your dependents are eligible for coverage on the first of the month following the date you were hired provided you make the pre-payment for your insurance. If you cannot afford to make a pre-payment, you may elect coverage to begin the month following prepayment being received. You and your dependents will be covered at the same time.

When Your Coverage Ends

For Fiscal Year 2010, your coverage will end on July 31, 2010.

If you leave your job with the City before the fiscal year ends (June 30, 2010), your coverage will end on the last day of the month in which you have paid the full month's premium. For example, if you leave at the end of the November you have already worked to pay for December's coverage. Your coverage will continue through the month of December. At which time you may be eligible to continue your coverage under Federal law. See page 37 for details.

When Your Dependent's Coverage Ends

Your dependent's coverage will stop on the same day your coverage stops or on the date your dependent no longer qualifies as eligible, whichever is earlier.

Your Eligible Dependents

Your dependents are eligible for coverage under the Plans if they are:

- your legal spouse or qualified domestic partner
- your unmarried children, including your stepchildren or adopted children, who are:
 - primarily dependent upon you for their support and maintenance and
 - younger than 19 or 23 years of age (depending on medical plan) or younger than 25 years of age and a full-time student enrolled in an accredited college or university
- children subject to a national medical child support order or if over-age
- mentally or physically disabled (subject to approval by medical insurance provider).

Covering Your Dependents

Your contributions for dependent coverage are made through your flexible benefits allotment and/or payroll deductions. This deduction can be made with either before (pre) tax dollars or after (post) tax dollars. If you choose to use before tax dollars, your gross wage will be reduced by the amount of the dependent medical insurance contribution. This means you will pay less taxes. It also means your gross wage on which your SPSP contributions are based is reduced.

If using your Flexible Benefits allotment, simply set aside the dollar amount you would like to use and this amount will automatically reduce your biweekly deduction from your paycheck. The remainder of the deduction can then be taken on either a pre-tax (before) or post-tax (after) basis.

Domestic partners can only be added to your medical insurance upon initial enrollment as a new hire or during open enrollment unless the domestic partner has lost their medical insurance or just became state registered. In either of these events, the domestic partner must be added within 30 days of the event.

Remember, if you are covering a non-dependent domestic partner, Flexible Benefit dollars cannot be used.

It is important to know that if you choose to cover your dependents on your medical insurance and decide during the year to drop your dependent's coverage, FBP dollars will be adjusted accordingly.

Dependent medical insurance premiums are not eligible to be reimbursed through the Dental/Medical/Vision Reimbursement option.

Coverage for Dependent Children

If you have dependent child(ren) ages 0 through 18, they may qualify for a no-cost medical, dental and vision insurance through the San Diego Kids Health Assurance Network (SDKHAN) or for a low-cost through Healthy Families. For further information, please call (619) 692-8026 or (800) 675-2229.

WAIVER OPTION

If you are covered by a comprehensive medical plan as of August 1, 2009, you may opt out of medical insurance. Comprehensive medical plans must include physicians office visits, major services and hospitalization. Proof of coverage will be required at the time of enrollment. If you become eligible for other coverage during the year you may not be eligible to change to the waiver option until the next open enrollment period.

If you have Medi-Cal insurance, you may not be eligible for this coverage once you are employed with the City because the City provides you medical insurance coverage. You will not be allowed to enroll for the Waiver Option.

If you have Veterans medical benefits, you will be required to show proof of comprehensive coverage. Some veterans medical benefits are covering treatment for injury only and no other medical benefits.

If you are a dependent on your parent's medical insurance, you may not be eligible to continue the medical insurance through your parent's employer because you are eligible for benefits through the City. If you are in this situation, please have your parent notify his/her employer to ask if you are still eligible to continue the medical insurance coverage before selecting the Waiver Option.

If you lose your other medical insurance coverage, you must enroll in a medical insurance from the City within 30 days from the loss of coverage.

MEDICAL PLANS

COVERED MEDICAL SERVICES	HEALTHNET HMO	HEALTHNET PPO
1. Type of Plan	A comprehensive Medical Maintenance Organization (HMO) serving California.	A comprehensive Preferred Provider Organization (PPO) medical plan that allows the choice of providers.
2. Choice of Physician and Hospital	You must select a Participating Medical Group (PMG) and then a physician within that group. There are 36 medical groups and over 1,000 primary care physicians in the San Diego county to choose from. Each family member may pick their own medical group and primary care physician. You may also change physicians during the year. If request is received by the 15th of the month, the transfer will be effective the 1st of the following month. If received after the 15th, it will be effective the first day of the second succeeding month.	You may select any licensed physician or hospital. Physicians of HealthNet's PPO Plan agree to accept payment made by HealthNet as payment in full, subject to provisions of this Plan, such as deductible and coinsurance. There are over 4,900 contracting physicians within the San Diego County area.
3. Deductibles/Maximums	No Deductible	\$250 deductible. Maximum of two deductibles per family per policy year.
Plan Year	Individual \$1,500	Individual \$2,000/\$4,000
Out-of-Pocket Maximum	Family \$3,000	Family \$4,000/\$8,000
4. Maternity	Prenatal visits paid in full. Nursery/newborn charges covered from date of birth if newborn is enrolled in plan within 30 days of birth. Elective Abortion: \$75 copayment	90%*
	Lamaze Classes: Not covered	Elective Abortion: 90%*
Infertility Treatment	50% copayment (limitations apply). 12 months continuous coverage waiting period.	Lamaze Classes: Not covered \$10,000 lifetime (IVF, Artificial Insemination, ZIFT not covered) 90%* 12 months continuous coverage waiting period.
5. HOSPITAL		
Days of Coverage	365 Days	365 Days
Room (Semi-Private)	Paid in Full	90%*
Extras (Services and Supplies)	Paid in Full	90%*
Intensive Care Unit	Paid in Full	90%*
Extended Facility Care	Paid in Full	90%*
Outpatient Surgery	\$50 copayment	90%*
Psychiatric Care⁽¹⁾	MHN Network Non-Network Paid in Full Not Covered (up to 30 days per policy year)	MHN Network Non-Network 90% 70% (Network and Non-Network combined. 15 days per policy year.)
Chemical Dependency	Paid in Full Not Covered	90% 80% (Network and Non-Network combined) Detoxification up to 3 days per admission. \$5,000 Inpatient maximum per policy year
6. PHYSICIAN'S SERVICES		
Surgical		
Surgeon	Paid in Full	90%*
Assistant Surgeon	Paid in Full	90%*
Anesthesiologist	Paid in Full	90%*
7. Physician Visits		
Office Visits	\$10 copayment	90%*
Hospital Visits	Paid in Full	90%*
Chiropractor	\$10 copayment/40 visits (combined with acupuncture benefits)	\$1,000 maximum per policy year 90%*
Well Baby	Paid in Full	90%*
8. Psychiatric Care		
Outpatient	MHN Network Non-Network \$10 copayment Not Covered 50 visits per plan year	MHN Network Non-Network 90% 80% 20 visits per policy year combined max

AT A GLANCE

COVERED MEDICAL SERVICES	HEALTHNET HMO	HEALTHNET PPO
9. Chemical Dependency (Drug & Alcohol) Outpatient	MHN Network \$10 copayment	Non-Network Not Covered 90% 24 visits per policy year combined maximum
10. Routine Check-Ups	\$10 copayment	90%; Deductible waived \$300 maximum payment per policy year; PPO benefit only
11. Prescription Drugs	Up to 30 day supply Generic: \$10 copayment Brand: \$20 copayment Mail Order: 90 day supply \$20/\$40 copayment Oral contraceptives & Norplant included. Smoking cessation therapy patches at copay. Managed Formulary	Not subject to deductible Up to 30 day supply Generic: \$10 copayment Brand: \$20 copayment Mail order: 90 day supply \$20/\$40 copayment Oral contraceptives & Norplant included. Smoking cessation therapy patches at copay. Managed Formulary
12. Registered Nurse	Paid in Full	90%*
13. Allergy Treatment	Test and Treatment Materials Included Paid in Full	90%*
14. Physical Therapy	\$10 copayment	90%* (\$2,000 maximum per policy year)
15. Hospice Care	Paid in Full	80%
16. Blood	Paid in Full	90%*
17. X-Ray & Lab	Paid in Full	90%*
18. Immunizations	\$10 copayment	90%*
19. Eye Examination	\$10 copayment	Not Covered
20. Ear Examination and Hearing Aids	Exam: \$10 copayment Hearing Aids: \$500 max/not to exceed 2 devices every 36 months	Exam: Covered as routine checkup Hearing Aids: 90%* \$1,000 maximum/every 24 months
21. Emergency Care Coverage Within the Service Area	\$50 copayment (waived if admitted)	90% after \$50 Deductible (waived if admitted)
*Outside the Service Area	\$50 copayment (waived if admitted)	90% after \$50 Deductible (waived if admitted)
22. Ambulance	Paid in Full	80%
23. Equipment Rental/Durable Medical Equipment (Such as wheelchairs, oxygen, iron lung and hospital bed.)	Paid in Full	\$2,000 per policy year 90%*
24. Prosthetics (Such as artificial limbs, and other corrective appliances.)	Paid in Full	\$2,000 per policy year 90%*
25. Acupuncture	\$10 copayment 40 visits per plan year (combined with chiropractic)	12 visits/policy year/90%*
26. Lifetime Benefit Maximum	Unlimited	Unlimited

* Represents amount payable when services are rendered by a HealthNet (PPO) provider. Payment for services by a non-PPO provider is 80% of UCR. An additional \$500 deductible per admission is required for services in a non-PPO hospital.

⁽¹⁾ Serious Mental Illness disorders are covered without limits.

MEDICAL PLANS

COVERED MEDICAL SERVICES	KAISER MEDICAL PLAN	SHARP HEALTH PLAN HMO
1. Type of Plan	A comprehensive group practice Medical Maintenance Organization (HMO).	A comprehensive Medical Maintenance Organization (HMO) serving San Diego & southern Riverside Counties.
2. Choice of Physician and Hospital	Services are provided by Kaiser Permanente Hospitals and Medical Offices throughout Southern California. Members may use any Kaiser Facility. Facilities are located in 8 regions throughout the U.S., covering 8 states. Within San Diego County, there are 16 medical offices, 3 offering urgent care services and 24 hour emergency services at the medical center. Members select a personal physician from Primary Care departments, physician changes are made at member discretion. Self referral allowed for select medical specialties, all others require referral from primary care physician. World wide coverage is available for urgent and emergency care.	You must select a participating Primary Care Physician (PCP). Each family member may pick their own PCP. There are over 800 primary care physicians in San Diego & southern Riverside Counties to choose from. These physicians practice through four major medical groups: Children's Physicians Medical Group, Sharp Rees Stealy with 17 locations throughout San Diego County, Sharp Mission Park, and Sharp Community Medical Group whose physicians usually practice in their own private offices. Additionally there are 41 smaller medical groups and 10 Community Clinic sites where PCPs are also located. You may change primary care physician during the year. The PCP change will take place no later than the first of the month after the request is made. Sharp Health Plan has 12 participating hospitals in San Diego and southern Riverside Counties.
3. Deductibles/Maximums	No Deductible	None
Plan Year	Calendar year	
Out-of-Pocket Maximum	\$1,500/\$3,000	\$1,500 individual/\$3,000 family
4. Maternity	All prenatal visits paid in full. Delivery paid in full after \$100 hospital copay.	Prenatal and postnatal visits paid in full. Nursery/newborn charges covered from date of birth if newborn is enrolled in plan within 30 days of birth.
	Elective Abortion: Outpatient \$20 Lamaze Classes: Covered for a fee	Elective Abortion: \$150 copayment Lamaze Classes: Not covered
Infertility Treatment	Diagnosis and treatment and artificial insemination Outpatient \$10 copayment (does not count towards Out of Pocket Maximum)	Diagnosis and treatment of the underlying condition. Artificial insemination up to a lifetime maximum of three inseminations. 50% coinsurance
5. HOSPITAL		
Days of Coverage	365 Days	365 Days
Room (Semi-Private)	\$100 copayment per admission	Paid in Full
Extras (Services and Supplies)	Paid in Full	Paid in Full
Intensive Care Unit	Paid in Full	Paid in Full
Extended Facility Care	Paid in Full	Paid in Full
Outpatient Surgery	\$50 copayment	\$50 copayment
Psychiatric Care⁽¹⁾	Up to 45 days \$100 copayment per admission	Maximum of 30 days per calendar year \$25,000 calendar year maximum/\$50,000 lifetime maximum Paid in Full
Chemical Dependency Rehabilitation	No Limit – Detox only \$100 copayment per admission if prescribed by a plan physician	Emergency services for acute drug or alcohol detoxification \$50 copayment
Inpatient	Residential Treatment – \$100 copay up to 60 days/calendar year not to exceed 120 days in 5 year period	Paid in Full
6. PHYSICIAN'S SERVICES		
Surgical		
Surgeon	Outpatient – \$10 copay/visit	Paid in Full
Assistant Surgeon		Paid in Full
Anesthesiologist		Paid in Full
7. Physician Visits		
Office Visits	\$10 copayment	\$10 copayment
Hospital Visits	Paid in Full	Paid in Full
Chiropractor	\$10 copayment/40 visits	\$10 copayment/40 visits
Well Baby	Paid in Full	Paid in Full
8. Psychiatric Care		
Outpatient	Individual sessions: \$10 per visit Group sessions: \$10 per visit Up to 20 visits per calendar year.	\$10 copayment

AT A GLANCE

COVERED MEDICAL SERVICES	KAISER MEDICAL PLAN	SHARP HEALTH PLAN HMO
9. Drug & Alcohol Outpatient	Treatment plan as prescribed by a plan physician \$10 copayment	\$10 copayment
10. Routine Check-Ups	Physical exams/school physicals Mammography \$10 copayment	\$10 copayment
11. Prescription Drugs	Up to 100 day supply Generic: \$10 copayment Brand: \$20 copayment Mail order: 100 day supply \$10/\$20 copayment Oral contraceptives, fertility drugs & dental prescriptions included.	Retail-Generic: 30 day supply \$10 copayment Retail-Brand Formulary: \$20 copayment Mail Order-Generic: 100 day supply \$20 copayment Mail Order-Brand Formulary: \$40 copayment
12. Registered Nurse	Paid in Full	Paid in Full
13. Allergy Treatment	\$10 copayment for testing Injections Paid in Full	Test and treatment materials included \$10 copayment
14. Physical Therapy	No charge in hospital; outpatient up to 60 days \$10 copayment	\$10 copayment
15. Hospice Care	In-Home Care Paid in Full	Paid in Full
16. Blood	Paid in Full	Self-donated blood services when specifically collected for a planned and covered surgical procedure. Paid in Full
17. X-Ray & Lab	Paid in Full	Includes advanced radiology Paid in Full
18. Immunizations	Paid in Full	\$10 copayment
19. Eye Examination	\$10 copayment	Paid in Full Materials not covered
20. Ear Examination and Hearing Aids	Exam: \$10 copayment Hearing Aids: \$500 max/ear (every 36 months)	Exam: \$10 copayment Hearing Aids: \$500 maximum/ear (every 36 months)
21. Emergency Care Coverage Within the Service Area *Outside the Service Area	\$50 copayment (waived if admitted but hospital copay applies) \$50 copayment (waived if admitted but hospital copay applies)	\$50 copayment (waived if admitted) \$50 copayment (waived if admitted)
22. Ambulance	Paid in Full	Paid in Full
23. Equipment Rental/Durable Medical Equipment (Such as wheelchairs, oxygen, iron lung and hospital bed.)	Paid in Full	Paid in Full
24. Prosthetics (Such as artificial limbs, and other corrective appliances.)	Paid in Full	\$10 copayment
25. Acupuncture	Not covered	\$10 copayment
26. Lifetime Benefit Maximum	Unlimited	Unlimited

⁽¹⁾ Serious Mental Illness disorders are covered without limits.

MEDICAL PLANS

COVERED MEDICAL SERVICES	MEA – SHARP CLASSIC HMO Available to MEA Employees	MEA-SHARP VALUE HMO Available to MEA Employees
1. Type of Plan	A comprehensive network of group practice and private practice physicians supported by 16 of San Diego's major hospitals organized as a Medical Maintenance Organization (HMO).	
2. Choice of Physician and Hospital	You will select a Primary Care Physician for each member of your family. There are over 2,500 primary care physicians and specialists in the Sharp Medical Plan locations throughout San Diego and Southern Riverside counties. Sixteen hospitals are part of Sharp Medical Plan including Children's Hospital and Medical Center, Fallbrook Hospital District, Sharp Grossmont Hospital, Inland Valley Hospital, Palomar Medical Center, Paradise Valley Hospital, Pomerado Hospital, Rancho Springs Medical Center, Sharp Chula Vista Medical Center, Sharp Coronado Hospital, Sharp Mary Birch Hospital for Women, Sharp Memorial Hospital, Sharp Memorial Outpatient Pavilion, Sharp Mesa Vista Hospital, Tri-City Medical Center and University Community Medical Center. You may change your Primary Care Physician once a month if you choose.	
3. Deductibles/Maximums	None	None
Plan Year Out-of-Pocket Maximum	\$3,000 per individual/\$5,000 per family	\$3,000 per individual/\$6,000 per family
4. Maternity	\$15 copayment for office visits; newborns covered automatically for first 31 days	\$500 Admission to hospital Prenatal and postnatal office visits paid in full Nursery/newborn charges covered from date of birth if newborn is enrolled in plan within 30 day of birth
Infertility Treatment	Elective Abortion: \$150 copayment 50% copayment Assisted Reproductive Treatment is not covered	Diagnosis and treatment of underlying condition 50% co-insurance
5. HOSPITAL		
Days of Coverage	365 Days	\$500 Admit to Hospital
Room (Semi-Private)	\$100 per admit copayment	
Extras (Services and Supplies)	Included in \$100 per admit copayment	
Intensive Care Unit	Included in \$100 per admit copayment	
Extended Facility Care	Included in \$100 per admit copayment	
Outpatient Surgery	Paid in Full	\$250 per procedure
Psychiatric Care⁽¹⁾	\$100 per admit copayment	Inpatient Psychiatric Care for Serious Mental Illness at \$500 Admit
Chemical Dependency	30 day max/\$25,000 lifetime max	Outpatient mental health combined with outpatient drug and alcohol treatment services \$40 per visit/20 per year
Rehabilitation	\$150 per admit copayment	Emergency services for acute drug and alcohol detox at \$100 per visit
Inpatient	Emergency detox \$100 per admit copayment	Emergency Detox No Inpatient stay for Chemical Dependency longer than the 3 day stay
6. PHYSICIAN'S SERVICES		
Surgical		
Surgeon	Paid in Full	No charge
Assistant Surgeon	Paid in Full	No charge
Anesthesiologist	Paid in Full	No charge
7. Physician Visits		
Office Visits	\$15 copayment	\$40 per visit
Hospital Visits	Paid in Full	No charge
Chiropractor	\$15 copayment/40 sessions (combined with acupuncture)	Not covered
Well Baby	\$15 copayment	No charge
8. Psychiatric Care		
Outpatient	\$15 copayment/no visit maximum (Direct access benefit)	20 visits per year/ \$40 per visit/ combined with drug and alcohol treatment

⁽¹⁾ Serious Mental Illness disorders are covered without limits.

AT A GLANCE

COVERED MEDICAL SERVICES	MEA – SHARP CLASSIC HMO Available to MEA Employees	MEA-SHARP VALUE HMO Available to MEA Employees
9. Drug & Alcohol Outpatient	\$20 copayment/20 sessions	Combined with Psychiatric outpatient
10. Routine Check-Ups	\$15 copayment	\$40 per visit
11. Prescription Drugs	Generic Formulary: \$10 copayment Brand Name Formulary: \$20 copayment Non Formulary: \$40 copayment Mail Order: 3 month supply of maintenance medication for 2 copayments	Retail-generic: 30 day supply \$15 Retail-brand formulary: 30 day supply \$35 Retail-brand non-formulary: 30 day supply \$50 Mail order-generic: 90 day supply \$30 Mail order-brand: 90 day supply \$70 Mail order-Brand non-Formulary: 90 day supply \$100
12. Registered Nurse/Home Health	100 visits maximum/Paid in Full	\$40 per visit/100 visits per year
13. Allergy Treatment	Testing: \$15 copayment; Injections: \$3 copayment	\$10 per visit/\$40 for testing
14. Physical Therapy	\$15 copayment	\$40 per visit/Maximum of 30 visits per year combined for types of therapy
15. Hospice Care	Paid in Full	Covered at no charge
16. Blood	Paid in Full (emergency transfusions only) ⁽²⁾	Certain copays may apply at time of visit depending on reason for visit
17. X-Ray & Lab	Paid in Full	Routine x-rays no charge Advanced x-rays \$100 per procedure
18. Immunizations	\$15 copayment	No charge for immunization/ \$40 when combined with office visit
19. Eye Examination	Discounted services	\$40 for routine eye exam in PCP's office No eye exam with Ophthalmologist covered
20. Ear Examination and Hearing Aids	Exam: \$15 copayment Hearing Aids: \$1,000 every 3 years	Not covered
21. Emergency Care Coverage Within the Service Area *Outside the Service Area	\$50 copayment (waived if admitted) \$50 copayment (waived if admitted)	\$100 per visit – waived if admitted to the hospital.
22. Ambulance	\$50 copayment	\$100 per trip
23. Equipment Rental/Durable Medical Equipment (Such as wheelchairs, oxygen, iron lung and hospital bed.)	Paid in Full	Maximum payment of \$2,000 per calendar year with 50% co-insurance
24. Prosthetics (Such as artificial limbs, and other corrective appliances.)	Paid in Full	Covered at 20% copay up to \$2,000 per year
25. Acupuncture	\$15 copayment/40 sessions (combined with chiropractic benefit)	Not covered
26. Lifetime Benefit Maximum	Unlimited	There are no lifetime maximums for this plan

⁽²⁾ Autologous blood covered with limitations. See member handbook.

DENTAL BENEFITS

DENTAL INSURANCE FOR YOU AND YOUR FAMILY

What Kind of Coverage is Available

The Dental insurance you are eligible to select is listed on your Flexible Benefits Worksheet.

For details on the dental plans offered, please order the brochure(s) from your payroll specialist.

For the annual value of the dental plans, please see Appendix D.

When Your Coverage Begins

All of the dental plans are prepaid plans. Prepaid means that the payment for this month pays for the following month.

For Fiscal Year 2010, your coverage will begin on August 1, 2009 because the payment in July pays for August coverage.

If you are a new employee, you and your dependents are eligible for coverage first of the month following the date you were hired provided you make the pre-payment for your insurance. If you cannot afford to make a pre-payment, you may elect coverage to begin the month following. You and your dependents will be covered at the same time.

When Your Coverage Ends

For Fiscal Year 2010, your coverage will end on July 31, 2010.

If you leave your job with the City before the fiscal year ends (June 30, 2010), your coverage will end on the last day of the month in which you have paid full premiums. However, you may be eligible to continue your coverage under Federal law. See page 37 for details.

When Your Dependent's Coverage Ends

Your dependent's coverage will stop on the same day your coverage stops or on the date your dependent no longer qualifies as eligible, whichever is earlier.

CITY'S DENTAL PLANS

Your Eligibility

If you are in a classification represented by MEA or Local 127, you are not eligible for these plans unless currently enrolled in the respective plan.

Your Eligible Dependents

Your dependents are eligible for coverage under the United Concordia Dental Plans if they are:

- your legal spouse
- your domestic partner
- your unmarried children, including your stepchildren or adopted children, who are:
 - primarily dependent upon you for their support and maintenance and younger than 23 or younger than 25 and a full-time student enrolled in an accredited college or university
- children subject to a national medical child support order or if over-age
- mentally or physically disabled (subject to approval by medical insurance provider).

Concordia Plus TCA21 DHMO Plan

What the Plan Covers

The plan covers most routine dental services at 100%. There are no deductibles and no annual maximum limits. A summary of the coverage is as follows:

- **Preventive – No charge.**
Exams, X-rays, cleanings, fillings.
- **Crowns, Bridges, Partials, Dentures.**
Copayments as listed in the United Concordia Schedule of Benefits.
- **Orthodontics (Braces).**
\$1,500 copayment for children; \$2,000 for adults.

To receive care, you may select one United Concordia dental office for yourself and your family or each family member may select separate dental offices for all services. You may change dental providers by calling 1-866-357-3304 toll-free.

Concordia Preferred Plan (DPO)

What the Plan Covers In-Network

A summary of the benefits when a United Concordia PPO dentist is used is as follows:

- **Preventive – No deductible; 100%**
Exams X-rays, cleanings, sealants.
- **Basic – No deductible; 80%**
Fillings, extractions, oral surgery, root canals, gum treatments.
- **Major – No deductible; 50%**
Crowns, bridges, partials, dentures.
- **Orthodontics – No deductible; 50%**
\$2,000 lifetime maximum.

What the PPO Plan Covers Out-of-Network

You and your dependents may also use any licensed dentist and receive the following coverage after a \$50 annual deductible (not to exceed \$150 for a family) on services except Preventive.

- **Preventive – No deductible; 80%**
Exams, X-rays, cleanings, sealants.
- **Basic; 60%**
Fillings, extractions, oral surgery, root canals, gum treatments.
- **Major; 50%**
Crowns, bridges, partials and dentures.
- **Orthodontics (Braces); 50%**
\$2,000 lifetime maximum.

Annual maximum \$1,500 – Per plan year (combined with PPO annual maximum).

How to File a Claim

United Concordia participating dentists have agreed to file a claim form on your behalf. If you use a non-United Concordia dentist, you may have to submit your own claim form but most dentists will submit it for you. Claim forms can be downloaded from the United Concordia web site at www.ucci.com.

Visit Us Online

For more information about United Concordia or to find out about your benefits, log on to www.ucci.com and register for *My Dental Benefits*. You can locate a provider, view your benefits, print ID cards, check claim status and many other features.

EMPLOYEE GROUP DENTAL

Local 127 Dental

Your Eligibility

If you are in a classification represented by AFSCME Local 127, you may enroll yourself and your dependents in one of the two Metlife/Safeguard Dental Plans.

Your Eligible Dependents

Your dependents are eligible for coverage under the Metlife/Safeguard Dental Plan if they are:

- your legal spouse or qualified domestic partner
- your unmarried children, including your stepchildren, adopted children, or children of a domestic partner who are:
 - primarily dependent upon you or your domestic partner for their support and maintenance
 - younger than 19 years of age or younger than 25 years of age and a full-time student enrolled in an accredited college or university
- children subject to a national medical child support order or if over-age
- mentally or physically disabled (subject to approval by medical insurance provider).

Metlife/Safeguard Dental Prepaid Plan

What the Plan Covers

You and your dependents select a dental office from the Metlife/Safeguard prepaid network. With Metlife/Safeguard each family member can select a different dental office. All services must be received from that office to be covered. The plan covers preventive and basic services without a copayment. Also, most complex procedures are covered with no copayment. All covered benefits are at no charge.

Benefit Summary:

- **Preventive – 100% Coverage**
- **Restorative – 100% Coverage**
- **Crowns, Bridges, Dentures – 100% Coverage**
See Summary of Benefits.
- **Orthodontics Benefits**
Copay is \$1,350 for two years of treatment.

See policy for full benefits.

Metlife/Safeguard Dental PPO Indemnity Plan

What the Plan Covers

This plan allows you to use any licensed dentist, but includes a panel of dentists who have contracted with Metlife to provide services at lower negotiated costs. The plan pays a reduced scheduled amount for covered services. An annual deductible of \$50 or total of \$150 per family applies to basic and major services only. The annual maximum benefit payable is \$2,000.

Benefit Summary:

	<u><i>In- Network</i></u>	<u><i>Out-of- Network</i></u>
• Preventive (Exams, X-rays, Cleanings, Sealants)	100%	100%
• Basic (Fillings, Oral Surgery, Root Canals, Periodontics)	80%	80%
• Major (Crowns, Bridges, Dentures)	50%	50%
• Orthodontics	Children (child to 19)	Adult
	\$1,500	\$1,500

For more details, refer to your Safeguard and Metlife Evidence of Coverage booklet available from your department’s payroll specialist or contact Safeguard/Metlife at (800) 880-1800.

MEA Dental

Your Eligibility

All MEA represented employees may select one of two dental plans provided by Delta Dental. You do not have to be a member or an agency fee payer in order to take these plans. Delta Dental of California offers two different dental plans to all MEA represented employees, the Delta Dental PPO and DeltaCare.

Your Eligible Dependents

Your dependents are eligible for coverage under the MEA Dental Plans if they are:

- your legal spouse, or qualified domestic partner, and your or your spouse’s child(ren) (including adopted, foster and stepchildren) provided they are:
 - unmarried; to age 24, extended to age 26 if a full-time student at an accredited college or university; or vocational, technical or trade school; and claimed as a dependent by you for federal income tax purposes
- children subject to a national medical child support order or if over-age
- mentally or physically disabled (subject to approval by medical insurance provider).

DeltaCare USA (DHMO)

What the Plan Covers

You choose a primary care dentist from one of more than 3,840 general dentists, specialists and orthodontists in 2,300 locations throughout California. You pay a set copayment (fees you pay to the dentist) for each covered dental procedure, and there are no claim forms, annual deductibles or maximums on general services. Many diagnostic and preventive services are covered at 100%. There is no charge for office visits. Your general dentist can refer you to a number of network specialists who provide tailored services when needed.

Benefit Summary:

- **Diagnostic, Preventive – 100% Coverage for most procedures**
Cleanings, X-rays, Examinations
- **Restorative – 100% Coverage for most procedures**
Fillings
- **Crowns, Bridges, Dentures**
Co-payments vary by procedure – as listed in your Evidence of Coverage
- **Orthodontics Benefits**
For dependent children to age 19, the copayment is \$1,700 plus start-up fees. For adults, the copayment is \$1,900 plus start-up fees as listed in your Evidence of Coverage

These are just some of the details of your DeltaCare coverage. Other covered services include tooth-colored material on molars, general anesthesia, IV sedation, crown lengthening, phase one-interceptive orthodontia, cosmetic bleaching. DeltaCare covers 275 procedures, all with specific and predetermined copayments. Please consult your Evidence of Coverage booklet for information on your benefits. If you have additional questions, call the toll-free Customer service line at (800) 422-4234 or visit Delta Dental's web site at www.deltadentalca.org/pmi.

Delta Dental PPO

What the Plan Covers

Diagnostic and preventive benefits are covered at 100%. A \$50 deductible per person per plan year is waived for diagnostic and preventive services if you receive treatment from a PPO dentist. There is a \$1,500 maximum per person each plan year. A complete list of benefits and limitations is listed in your Evidence of Coverage.

Benefit Summary:

- **Diagnostic, Preventive – 100% for either in-network or out-of-network Delta dentists**
Cleanings, X-rays, Examinations
- **Basic Benefits – 90% of PPO dentist's allowed fee for in-network dentists; for out-of-network, 80% of Premier dentist's allowed fee or the fee that satisfies a majority of Delta dentists**
Extractions, Fillings, Root Canals, Periodontal treatment, Sealants
- **Crowns, Bridges, Dentures – 60% of PPO dentist's allowed fee for in-network dentists; for out-of-network, 50% of Premier dentist's allowed fee or the fee that satisfies a majority of Delta dentists**
- **Orthodontics Benefits – 50% of PPO dentist's allowed fees (\$1,500 lifetime maximum per person); for out-of-network, 50% of Premier dentist's allowed fee or the fee that satisfies a majority of Delta dentists**

Your plan allows you to see any licensed dentist, but when you see a PPO dentist your out-of-pocket expenses are lower. Although your program covers many of the most commonly needed services, some procedures are not covered. To find out whether a particular procedure is covered, or how much of it is paid for by your program, check your Evidence of Coverage booklet. For further questions, call the toll-free Customer Service line at (888) DELTA CS (888-335-8227) or visit Delta Dental's web site at www.deltadentalca.org. You may also contact them by e-mail at cms@delta.org.

VISION BENEFITS

OPTIONAL COVERAGE FOR YOU AND YOUR DEPENDENTS' EYE CARE

What Kind of Coverage is Available

The Vision insurance you are eligible to select is listed on your Flexible Benefits Worksheet.

For details on the vision plans offered, please order the brochure(s) from your payroll specialist.

See Appendix D for the annual value of the various plans.

When Your Coverage Begins

All of the vision plans are prepaid plans. Prepaid means that the payment for this month pays for the following month.

For Fiscal Year 2010, your coverage will begin on August 1, 2009 because the payment in July pays for August coverage.

If you are a new employee, you and your dependents are eligible for coverage first of the month following the date you were hired provided you make the pre-payment for your insurance. If you cannot afford to make a pre-payment, you may elect coverage to begin the month following. You and your dependents will be covered at the same time.

When Your Coverage Ends

For Fiscal Year 2010, your coverage will end on July 31, 2010.

If you leave your job with the City before the fiscal year ends (June 30, 2010), your coverage will end on the last day of the month in which you have paid full premiums. However, you may be eligible to continue your coverage under Federal law. See page 37 for details.

If you are on an approved "Leave Without Pay" status, you may be eligible to continue your coverage by paying the required premium. Risk Management will send you a letter asking if you want to continue your coverage. If you don't continue, your coverage will stop on the last day of the month in which you worked or you don't pay your required premium.

When Your Dependent's Coverage Ends

Your dependent's coverage will stop on the same day your coverage stops or on the date your dependent no longer qualifies as eligible, whichever is earlier.

CITY'S BLUE SHIELD OF CA/MESVISION PLAN

Your Eligibility

If you are in a classification represented by MEA, you are not eligible for this plan.

Your Eligible Dependents

Your dependents are eligible for coverage under the Blue Shield of CA/MESVision Plan if they are:

- your legal spouse or qualified domestic partner
- your unmarried children, including your stepchildren or adopted children, who are:
 - primarily dependent upon you for their support and maintenance and younger than 23 or younger than 25 and a full-time student enrolled in an accredited college or university
- children subject to a national medical child support order or if over-age
- mentally or physically disabled (subject to approval by medical insurance provider).

What the Plan Covers

Vision services are provided by Blue Shield of CA/MESVision participating providers. MESVision has the largest network of providers in California with over 18,000 provider locations nationwide including LensCrafters, Wal-Mart, Sears, Target Optical, Pearl Vision and Sam's Club. When you use a participating provider, most of your eyecare services are provided at no additional charge. No ID card or claim forms needed.

A summary of the benefits is as follows:

- **Eye exam** – every 12 months – no charge
- **Lenses** – standard – every 12 months – no charge
- **Frames** – every 24 months – no charge, \$105 retail allowance
- **Contact Lenses** – Medically necessary – no charge when required for Anisometropia or Keratoconus, or following cataract surgery, or when visual acuity cannot be corrected to 20/40 in the better eye, and conventional type lenses will not improve visual acuity to 20/40 or better. Provided in lieu of glasses.
- **Contact Lenses** – Cosmetic purposes – every 12 months – \$100 member allowance -- Provided in lieu of glasses
- **LASIK** – 15% discount through TLC Vision (www.tlcvision.com)
- **Discount Vision Plan** – receive a 20% discount at participating provider locations on extras or additional materials reducing your out-of-pocket expenses even more.

If Covered Services are received from a Non-Participating Provider, the patient is responsible for paying the Non-Participating Provider in full at the time services are rendered.

EMPLOYEE GROUP VISION

MEA Vision

Your Eligibility

MEA sponsors a vision plan which is available to all employees in classifications represented by MEA. You do not need to be a member or agency fee payer to enroll in this plan.

Your Eligible Dependents

Your dependents are eligible for coverage under the EyeMed Vision Care Access B if they are:

- your legal spouse, or qualified domestic partner, and your or your spouse's child(ren) (including adopted, foster and stepchildren) provided they are:

- unmarried; through age 23, extended to age 26 if a full-time student at an accredited college or university; or vocational, technical or trade school; and claimed as a dependent by you for federal income tax purposes
- children subject to a national medical child support order or if over-age
- mentally or physically disabled (subject to approval by medical insurance provider).

What the Plan Covers

You will receive quality eyewear and eye care services from one of EyeMed Vision Care's participating providers. The EyeMed panel consists of a national network of private practicing optometrists, ophthalmologists and opticians as well as the nation's leading optical retailer, LensCrafters.

A summary of the benefits for the Premier Plan is shown below:

Access B

- **Eye exam** – once every 12 months – no charge
- **Frames** – \$100 allowance for frames and a 20% discount over \$100 on any provider frame
- **Lenses** – standard plastic lenses, all sizes, covered in full: single vision, bifocal, trifocal, basic progressive
- **Lens Options** – discounted charges are paid for by the enrollee and added to the base price of the lens
- **Contact Lenses** – \$115 allowance per benefit year for conventional and disposable contact lenses; 15% discount on amount exceeding \$115 for conventional only
- **Laser Surgery** – 15% off of LASIK and PRK fee

Every 12 months the Access B plan will cover:

- two pair of eyeglasses; **or**
- two contact lens allowances; **or**
- one pair of eyeglasses **and** one contact lens allowance.

For further details please request the EyeMed brochure from MEA's Benefits Department at (619) 677-3952.

REIMBURSEMENT ACCOUNTS

ADDITIONAL WAYS TO PLAN AND SAVE THROUGH FLEXIBLE BENEFITS

Reimbursement Accounts for You

The City of San Diego provides certain benefit options as part of your Flexible Benefits Plan: Dental/Medical/Vision Reimbursement and Dependent Care Reimbursement. These plans are generally known as Flexible Spending Accounts (FSA).

These special accounts allow you to set aside tax-free dollars to pay for your health care and dependent care expenses. The amounts you set aside through payroll deduction will be termed Reimbursement Supplements.

Reimbursement Accounts Offer a Number of Important Advantages!

- They help you to budget your health care and dependent care expenses in advance of the upcoming year.

- You can fund these accounts through your left over Flexible Benefits dollars, convenient payroll deductions, or a combination of both.
- In most cases, these accounts save you from paying more taxes than through either itemized deductions or tax credits.

Savings on Taxes Mean More Money for You and Your Family

Because your contributions to both the Dental/Medical/Vision Reimbursement Supplement Account and the Dependent Care Reimbursement Supplement Account are taken out before your pay is taxed, you have more spendable income! Take a look at the chart below.

How to Save Taxes with the Dental/Medical/Vision and Dependent Care Reimbursement Supplement Accounts

	WITH THE SUPPLEMENT ACCOUNTS	WITHOUT THE SUPPLEMENT ACCOUNTS
BIWEEKLY BASIC EARNINGS:	\$1,500	\$1,500
MEDICAL CARE EXPENSES THROUGH THE DENTAL/MEDICAL/VISION REIMBURSEMENT SUPPLEMENT ACCOUNT:	\$70	\$0
CHILD CARE EXPENSES THROUGH THE DEPENDENT CARE REIMBURSEMENT SUPPLEMENT ACCOUNT:	\$150	\$0
REVISED BASIC EARNINGS:	\$1,280	\$1,500
ESTIMATED TAX (28%):	\$358	\$420
NET EARNINGS:	\$922	\$1,080
AFTER TAX MEDICAL CARE EXPENSES:	\$0	\$70
AFTER TAX CHILD CARE EXPENSES:	\$0	\$150
SPENDABLE INCOME:	\$922	\$860
INCREASE IN PAY DUE TO THE SUPPLEMENT ACCOUNTS	\$62	

By reducing your income, your SPSP contributions will be reduced as well. This is because Reimbursement Supplement Accounts reduce the wage base on which your contributions to this account is based. The following example illustrates the effects of Supplement Accounts on SPSP:

	WITH SUPPLEMENT ACCOUNTS	WITHOUT SUPPLEMENT ACCOUNTS	WITH SUPPLEMENT ACCOUNTS	WITHOUT SUPPLEMENT ACCOUNTS
BIWEEKLY EARNINGS:	\$1,500	\$1,500	\$2,000	\$2,000
DENTAL/MEDICAL/VISION REIMBURSEMENT SUPPLEMENT ACCOUNT CONTRIBUTIONS:	\$70	\$0	\$70	\$0
DEPENDENT CARE REIMBURSEMENT SUPPLEMENT ACCOUNT CONTRIBUTIONS:	\$150	\$0	\$150	\$0
REVISED BASIC EARNINGS:	\$1,280	\$1,500	\$1,780	\$2,000
SPSP:	\$77	\$91	\$108	\$121
CONTRIBUTION:	(6.05%)	(6.05%)	(6.05%)	(6.05%)
CITY MATCH:	\$77	\$91	\$108	\$121

The San Diego City Employees Retirement System (SDCERS), 401(k) and Deferred Compensation contributions will not be affected by your Reimbursement Supplement Account contributions.

How Do I Participate?

If you are eligible to participate in the City's Flexible Benefits Plan, you can enroll in one or both of the Reimbursement Accounts during the open enrollment period. Your accounts will be effective July 1, 2009. To participate, simply determine how much you would like to contribute to each account for the plan year from Flexible Benefits, payroll or both. Write these amounts on your 2009-2010 Flexible Benefits Plan Worksheet and when enrolling for your benefits through EASY ENROLL enter the amounts you have listed.

Estimate Your Expenses Carefully

When you enroll in the Flexible Benefits Plan for the coming year, you will need to decide how much you want to set aside in one or both Reimbursement Accounts. Be sure you estimate your expenses carefully so you do not overfund your accounts. The IRS has some special rules that apply to your use of your Reimbursement Accounts because of the generous tax advantages they offer:

- **If you do not use all the money in your Dependent Care or Dental/Medical/Vision Reimbursement Accounts, you will lose it at the end of the Plan Year.** IRS regulations state that you must forfeit any money left in your Reimbursement Accounts when the Plan Year ends. These forfeitures cannot be deducted on your income tax return. Plan carefully before deciding how much to contribute to your Reimbursement Accounts. Set aside only the dollar amount you are certain you will use.
- **Dollars you put into your Dependent Care Reimbursement Account cannot be transferred to your Dental/Medical/Vision Reimbursement Account and vice-versa.** The accounts are separate, and the money you allocate for one kind of expense cannot be used for the other.

- **You may not change the amount you put into an account for the Plan Year.**
- **All claims for eligible expenses incurred during the plan year (July 1, 2009 – June 30, 2010) must be submitted no later than July 31, 2010.**
- **Claims for expenses incurred while eligible for benefits must be received within thirty (30) days from date of termination or becoming ineligible, in order to be eligible for reimbursement.**

DENTAL/MEDICAL/VISION REIMBURSEMENT

A TAX FREE WAY TO PAY FOR ADDITIONAL EXPENSES

Dental/Medical/Vision Reimbursement Account

Your elections under the Flexible Benefits Plan will cover most routine medical, dental, and vision expenses during the year. But you may have additional expenses throughout the year that are not covered by the plans you elected, such as deductibles, copayments, and coinsurance amounts that are part of your out-of-pocket expenses for health care treatment. If you have not set aside the money for these expenses in the Dental/Medical/Vision Reimbursement Account, you will be paying these expenses with after-tax dollars.

The Dental/Medical/Vision Reimbursement Account is an excellent way to pay for some of these expenses. When you establish this account, you set aside tax-free dollars to cover eligible health care expenses you expect to incur throughout the year.

There Are a Lot of Eligible Expenses!

You have a wide variety of expenses which could be paid with the money in your Dental/Medical/Vision Reimbursement Account. Some of these include:

- Medical, dental, and vision care annual deductibles, copayments, and coinsurance amounts
- Your share of costs for routine check-ups, well baby care, immunizations, and other preventive benefits.
- Prescribed supplies or medicines
- Prescription sunglasses
- LASIK or similar vision correction surgery
- Over-the-counter medications and supplies to treat illness or injury

Certain expenses are not eligible for reimbursement through a Dental/Medical/Vision Reimbursement Account. These include such expenses as:

- Your premium payments for medical, dental, and vision coverage plans for yourself or your dependents.
- Funeral expenses
- Nonprescription vitamins for overall general health
- Diaper service
- Dependent care expenses for a child or a disabled member of your household
- Cosmetic treatment for cosmetic reasons

The General Rule for Determining an Eligible Expense

- The IRS must consider the medical expense to be a tax deductible item and
- The expense must not be covered under any employer-sponsored or personal insurance plan and
- You may not deduct the expense on your income tax return.

Remember, if you do decide to itemize deductions on your federal tax return, your medical expenses must exceed 7½% of your annual gross income to qualify for a deduction. Because of this rule, the Dental/Medical/Vision Reimbursement Account may be a better way to reduce your tax bill. With the Dental/Medical/Vision Reimbursement Account, your contributions are not taxed at all.

Whose Expenses Can Be Reimbursed?

You may submit claims for yourself and your eligible dependents. Eligible dependents include:

- Your spouse and dependent children
- Any regular member of your household so long as you provide over half of the individual's financial support and claim the individual as a dependent on your tax return. A copy of your tax return will be required for the year you claimed the individual as a dependent.

Dollars and Sense

With a Dental/Medical/Vision Reimbursement Account, you can set aside from \$26 up to \$5,000 a year (from \$1.00 to \$192.30 biweekly) through convenient, tax-free payroll deductions and/or you may also use dollars left over from when you selected your flexible benefits plan options. As you and your eligible dependents incur expenses throughout the plan year, you can then reimburse yourself 100% up to the amount you set aside in your account for the upcoming year.

All health care expenses you incur during the plan year (July 1 to June 30) must be submitted for reimbursement by July 31st of the following plan year. You are eligible for your entire annual Dental/Medical/Vision Reimbursement Account amount at any time during the plan year.

The Following Conditions Must Be Met

You must submit claims to be reimbursed for expenses incurred for you and your dependents.

You must be in a pay status, including Industrial Leave and Long-Term Disability. If you are on Leave Without Pay, amounts will not accrue to this option. Any expenses incurred during this unbenefitted status will not be eligible for reimbursement unless you continue to pay the necessary premiums. Your annual allotment will be reduced by the amount of missed contributions during this unbenefitted status.

You must use your money by June 30, 2010. If you do not, all remaining amounts will be forfeited. This benefit is not carried forward to the next benefit year.

What Kind of Doctors?

Services must be received from a physician who is licensed to practice medicine and surgery as a doctor of medicine, M.D. or as a doctor of osteopathy, D.O. While acting within the scope of his/her license and to the extent that benefits are provided, physician shall include a person licensed to practice as a dentist (including orthodontist, dental assistant, or hygienist acting under the direction of a licensed dentist), podiatrist, chiropractor, clinical psychologist, optometrist, or ophthalmologist.

What Kind of Expenses?

Reimbursements will be made for services, medications, and supplies that have been prescribed by a licensed physician or those licensed specialists shown under the "What Kind of Doctors" section above. The expenses must also meet Internal Revenue Service guidelines.

Internal Revenue Code §213 defines "medical care" as amounts paid for the "diagnosis, care, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body." Based on IRS rules, the type of expenses which may be reimbursed under the City's reimbursement plan are limited. For example, the following expenses are not reimbursable:

- premiums for other health coverage, including premiums paid for dependent health coverage through the City's plans or for health coverage under a plan maintained by the employer of your dependent (including your spouse)
- weight loss programs unless medically necessary
- food or food supplements in connection with medically necessary weight loss programs
- personal items (mattress, television, computer, spa)
- eyeglass frames alone without prescription lenses
- transportation (mileage and parking fees)
- lodging

A general list of allowable expenses is provided in Appendix F. The general list is in no way an exhaustive list of what is reimbursable under Dental/Medical/Vision Reimbursement. It is also important to note that not all expenses allowed to be claimed on your taxes under IRC §213 are eligible to be reimbursed under the City's Dental/Medical/Vision Reimbursement Plan.

When Are Expenses Eligible?

Expenses must be incurred (received) during the plan year and while you are eligible for the benefit.

Expenses are treated as having been incurred when the participant is provided with the medical care that gives rise to the medical expenses, and not when the participant is formally billed or charged for, or pays for the medical care.

In the case of supplies, such as eyeglasses, prescriptions, etc., expenses are deemed incurred at the time they are ordered, not when paid for or received.

Crowns, bridges and root canal are deemed incurred at the time they were initially started, not when they were permanently set.

Orthodontia

In the case of non-cosmetic orthodontic treatment (braces), it is recommended that you speak with a Flexible Benefits representative before contracting for orthodontia or designating money for reimbursement through the Dental/Medical/Vision Reimbursement account.

Due to the unique nature of orthodontia expenses, the following special documentation requirements have been established:

- the first orthodontia claim submitted must include a copy of the written agreement between you and the orthodontist, indicating the total estimated charges and the period of treatment.
- all claims submitted must include statements or receipts from the orthodontist as evidence of services rendered.
- if you have insurance, you must submit the claim to the insurance company and then submit the Explanation of Benefits worksheet with your first D/M/V claim.

If you pay for orthodontic treatment over time, the plan will allow for reimbursement as follows: A maximum of 33 1/3% of the total cost can be reimbursed at the initiation of the services, if your first payment was less than 1/3 of the total cost, the initial reimbursement will be limited to that amount. The balance will be allowed based on the orthodontist's regular billing dates (monthly, quarterly, etc.) over the course of the treatment period.

Some orthodontists offer a discount if payment in full is made at the beginning of treatment. If you take advantage of this option, it is important to note that the D/M/V Reimbursement Plan can only reimburse for services actually rendered during the effective plan year (July 1 – June 30). Therefore, a maximum of 33 1/3% of the total cost can be reimbursed at the initiation of the services. The balance will be prorated over the number of months of treatment stated under your contract. The monthly fee will be reimbursed thereafter as long as treatment was rendered that month. The following example is provided for further explanation:

In October, you contract with your orthodontist to have braces put on your child's teeth. During the first visit (November) the child is x-rayed and fitted for braces. During the second visit (December), the braces are applied to the teeth. During the next 15 months, monthly visits are made to adjust the braces. Eventually (18 months after the first visit, if all goes as planned) the braces will be removed, and a retainer will be fitted for use thereafter. For all these services, you pay \$3,000 on the date of the first visit.

In this example, because all the services will not be received in the plan year, you are not eligible to receive reimbursement for the full \$3,000 in the plan year. You will need to have the orthodontist apportion (separate) the \$3,000 to the office visits your child makes over the contract's 18-month period. If the orthodontist estimates that one-third of the total time that he or she will spend with the child (and one-third of the expense for supplies) occurred during the first two visits, and that the remaining time and expenses will be spread evenly over the remaining months, then \$ 1,000 is eligible to be received after the December visit and the remaining \$2,000 will be eligible to be paid each month thereafter in equal amounts ($\$2,000/16 = \125). In this case, the amount eligible for reimbursement in FY 2010 is \$1,750 ($\$1,000 + \$125 \times 6 \text{ months} - \text{January through June}$).

The orthodontist's letter certifying that the orthodontic treatment is not cosmetic and apportioning the costs must be attached to the first reimbursement claim form submitted.

Information Before You File a Claim

- Services, prescribed medicines, and supplies must be received during the benefit year (July 1, 2009 through June 30, 2010 or up to date of termination, whichever comes first).
- All claims for reimbursement for the 2009-2010 Benefit Year must be received in Risk Management no later than July 31, 2010, as indicated by the Flexible Benefits Section's time stamp or 30 days after termination or becoming ineligible for this plan, whichever is earlier.

How to File a Claim

In order to receive payment for Dental/Medical/Vision services, you must submit a claim reimbursement form and a receipt which includes the following information:

- the type of service or supply received
- the provider of the service or supply
- the person receiving the service
- the date the service or supply was received
- how much it cost

If you have dental/medical/vision insurance coverage through your spouse, a prior employer, or any other reason, you will be required to complete a claim form which takes into account coordination of benefits between this plan and the other plans. The City may determine if that other plan is primarily responsible for paying for all or part of your expenses you claim under the Dental/Medical/Vision Reimbursement. If the other plan must pay for your expenses, you may not receive reimbursement for that expense. **You will not be reimbursed until an EOB has been received reflecting the other insurance's payment.**

Your reimbursements under the Dental/Medical/Vision reimbursement will be made up to the amount you elected on your 2009-2010 Reimbursement Account.

Claims will be processed for payment biweekly. Reimbursement payments are included on your paycheck. Processing time varies but you can expect at least 4-6 weeks.

NOTE: This is only a summary of the Dental/Medical/Vision Plan. You should consult the Plan Document to find out the exact terms and conditions of your coverage under this Plan.

DEPENDENT/CHILDCARE REIMBURSEMENT

TAKING CARE OF THOSE IN YOUR CARE

A Dependent Care Reimbursement Account works much like a Dental/Medical/Vision Reimbursement Account. If you have eligible dependent care expenses, you can set aside tax-free dollars to cover these expenses throughout the year.

The expenses incurred by your eligible dependents for “day” care may be reimbursed by the City. Dependent care expenses are defined as:

- amounts paid for the care of a dependent in your home or at a dependent care facility which meets all the applicable requirements of state or local law, or is exempt from those requirements.

Your Eligible Dependents

Your dependent care expenses are eligible for reimbursement under the City’s plan if your expenses are for a dependent who is:

- your child who is younger than age 13
- a member of your immediate family who are physically or mentally incapable of caring for themselves
- dependents who you may claim an exemption for Federal income tax purposes.

When You Can Be Reimbursed

Your expenses must be incurred on or after your and your dependent’s effective date of coverage. The date you receive services is the date they will be deemed incurred.

The City will reimburse your dependent care expenses when you are in a pay status, including Industrial Leave and Long-Term Disability. If you are on Leave Without Pay or other unbenefitted status, amounts will not accrue to this option. Any expenses incurred during this unbenefitted status will not be eligible for reimbursement.

How to File for Reimbursement

To receive reimbursement for dependent care expenses, you must:

- complete a claim reimbursement form
- attach a paid bill, receipt, or other written evidence of payment which reflects when the service was rendered and how much you paid. All proof of payment must be signed by the provider of the services.

Also, you need to supply the following information about the care provider:

- name of provider
- their address
- their Social Security number or taxpayer identification number.

The Internal Revenue Service requires the above information, whether you use the tax credit or the Dependent Care Reimbursement option.

If you have not used up all the money in your Dependent Care Reimbursement account by June 30, 2010, then the remaining amount will be forfeited.

All claims for reimbursement for the 2009-2010 Benefit Year must be received by the Flexible Benefits Plan Section no later than July 31, 2010 (as indicated by the Flexible Benefits Section’s time stamp), or 30 days after termination, whichever is earlier.

Claims will be processed biweekly, up to the amount accrued to your account. Reimbursement payments are included on paychecks.

Reimbursement payments, in excess of \$5,000 per calendar year, will be taxed at the time received.

Who Can Set Up an Account?

If you are a single working parent and pay for dependent care for eligible dependents, you can set up a Dependent Care Reimbursement Account. If you are married, your spouse must also work or go to school full-time to qualify you for the Dependent Care Reimbursement Account.

Who is Eligible for Coverage by a Dependent Care Reimbursement Account?

- Your child under the age of 13 whom you claim on your federal tax return
- Other dependents, such as your spouse, an elderly parent, or an older child who cannot care for themselves because of a physical or mental disability, and whom you claim as a dependent on your tax return.

A dependent can be any person who regularly lives with you at least 8 hours a day and that you provide at least half of their financial support. Dependents do not have to be members of your family.

What Are Eligible Dependent Care Expenses?

Like the Dental/Medical/Vision Reimbursement Account, you have a wide variety of expenses which could be paid with the money in your Dependent Care Reimbursement Account. Some of these include:

- At-home day-care provider(s), unless the care is provided by your child under 19 years old, or by someone else you claim as a dependent
- Day-care centers
- Summer day camps
- Nursery schools
- Preschool
- Child care provided before or after school hours

What Are NOT Eligible Dependent Care Expenses?

Certain expenses are not eligible for reimbursement through a Dependent Care Reimbursement Account. These include such expenses as:

- Overnight camps
- Babysitting so you can attend a social event
- Food and education expenses for a child in kindergarten or higher
- Payment for dependent medical care expenses
- Cost of care provided by another dependent
- Tuition or school registration
- amounts paid to your child younger than 19 who cares for your dependent
- amounts paid to your dependent if you are entitled to claim that dependent as an exemption for Federal income tax purposes
- amounts paid for or reimbursed under any Federal, State or local child care assistance program
- amounts paid for or reimbursed under your spouse's employer- sponsored program or under an educational institution program, or any other source other than this plan.

How Much You Can Contribute?

If you are single or married (filing a joint return), you can set aside from \$26 up to \$5,000 for your household – tax-free – per plan year in your Dependent Care Reimbursement Account. If you are married and you and your spouse file separate returns, you can set aside up to \$2,500 per year tax free.

You can contribute from \$1.00 to \$192.30 each paycheck or a combination of your remaining Flexible Benefits allotment and payroll deduction by writing the amount on your 2009-2010 Flexible Benefit Plan Worksheet and entering the annual amount through EASY ENROLL.

The Effect on Your Taxes

- Dependent care expenses must meet all Internal Revenue Service requirements.
- You will receive a written statement showing the amounts paid by the City for the previous calendar year. The City will provide this statement on or before January 31st of each year. The City will report the amount you received during the year on your W-2.
- § 21 of the Internal Revenue Code allows an income tax credit for dependent care expenses of up to \$3,000 for one dependent and \$6,000 for two dependents. This credit will be reduced, dollar for dollar, by the amounts you receive under the City's plan. For example:

You have one child and \$4,000 in dependent care expenses. You receive \$1,000 from the Dependent Care Reimbursement option. You will only be able to use \$2,000 toward the dependent care tax credit (\$3,000 – \$1,000 = \$2,000)

Because of this law, you will have to decide if the Dependent Care Reimbursement option or the tax credit, or a combination of both, will be the best choice for you.

Dependent Care Reimbursement Account vs. Tax Credit

Before enrolling in a Dependent Care Reimbursement Account, you should evaluate whether a tax credit taken on your federal income tax return will save you more money than the Dependent Care Reimbursement Account.

You Should Consider That:

- Your eligible dependent care expenses are the same expenses that would qualify for credit on your federal income tax return.
- You may not take a tax credit for expenses funded through your reimbursement account. In fact, each dollar you place in the dependent care account reduces the amount you can claim for a tax credit by \$1.

To help you determine if the tax credit offers you greater tax advantages than a reimbursement account, you may want to consult a tax advisor.

401(K) PLAN

A 401(k) PLAN CAN BE COORDINATED WITH FLEXIBLE BENEFITS

The City of San Diego's 401(k) Plan allows you to systematically save for retirement and shelter your savings from current taxes.

Participating in the 401(k) Plan does not affect benefits for the City's other Pension/Savings Plans.

Your Eligibility

You are eligible for the 401(k) Plan if you are directly employed by the City of San Diego.

Medicare Tax

If you were hired on or after April 1, 1986, all amounts contributed to 401(k) ARE subject to Medicare taxes (1.45%) at the time of contributions. These taxes will be withheld from your paycheck.

Sources of Contributions:

- Contributions to 401(k) may be made through the Flexible Benefits Plan and/or payroll deductions.
- If you choose to make your contributions through the Flexible Benefits plan, a minimum contribution of \$1.00 per pay period is required (\$26 annual).
- If you make contributions outside of the Flexible Benefits Plan through payroll deductions, a minimum of \$10.00 per pay period is required. You may change payroll deductions at any time.

Maximum Contribution Amounts

The maximum contribution you may make to your 401(k) Plan in calendar year 2009 is \$16,500. If you are age 50 or over as of 12/31 of this year, you can contribute an additional \$5,500. Annual savings from all sources (contributions under the Flexible Benefits Plan and through payroll deductions) must not exceed the limits found in Internal Revenue Code §415. The amount is the combined 401(k) and SPSP (including City match) contributions which cannot exceed \$49,000 for calendar year 2009.

Because the maximum limits are counted on a calendar year (January to December) and the Flexible Benefits Plan contributions are based on a fiscal year (July 1 to June 30), you may overcontribute or undercontribute from one year to the next. This can be avoided by calculating your maximum for a calendar year and evenly distributing the contributions each pay period throughout the year.

If you overcontribute for any reason, those over-contribution monies will be refunded to you.

Electing or Changing Contributions/Investment Choices

Current Employees

During open enrollment you change your contributions using EASY ENROLL. If you are enrolling for the first time and you want to invest your contributions in specific funds you must contact Wachovia Participant Services lines at 1-800-626-6504 or go to Wachovia.com/myretireplan to designate your fund selection(s). Until you make your fund selection(s), your contributions will be defaulted into the Vanguard LifeStrategy Moderate Growth Fund (Investor Shares). When contacting Wachovia via the services line number, you will need your personal identification number (PIN) previously provided to you by Wachovia. This PIN is different than the PIN you use to enroll for your benefits using EASY ENROLL. If you've lost or forgotten your Wachovia PIN, contact Participant Services. You may also make investment choices and changes, move current balances from investment fund to fund and/or make investment fund elections for future contributions via the web at www.wachovia.com/myretireplan once you have set up your personal account. You will need your Wachovia PIN in order to set up your account the first time.

New Employees

If you enroll for 401(k) as soon as you begin working for the City of San Diego, you must complete an enrollment form in order to elect the amount to be contributed through payroll deduction, if any, and how you want your contributions invested. Wachovia will send you a PIN upon being notified by the City that you are a new employee. You will use this PIN to make changes to your investment elections or payroll contributions in the future.

For additional information about how 401(k) works and/or the investment options, call Wachovia at 1-800-626-6504 or Employee Savings at (619) 236-6600 to get a Summary Highlights brochure or ask questions.

When You Receive Money from the 401(k) Plan

- The 401(k) Plan is designed to provide savings for your retirement years. Because of this, withdrawals from your 401(k) are not permitted unless you have a financial hardship. The term “financial hardship” means an immediate and heavy financial need that cannot be satisfied from other resources that are reasonably available to the Participant as defined by Internal Revenue Code Section 401(k) and the corresponding Treasury Regulations pertaining to that section.
- You may borrow up to 50% of your account balance (not to exceed a combined total of \$50,000 for all loans in the last 12 months). Only one outstanding loan is permitted.

- You may receive the full value of your account when you terminate, retire or become permanently and totally disabled, by taking a lump sum from your account. In the event of your death, the full value of your account is paid to your beneficiary. When you leave City of San Diego employment, you have the option of rolling your account balance into an IRA or another qualified employer-sponsored plan (according to their plan rules) or leaving your money in your account and/or begin receiving installment payments while continuing to direct your investments. Distributions of money that has not been taxed are subject to an immediate 20% federal income tax and a 2% state income tax withholding. Penalty taxes are imposed for early distributions. You should consult a tax advisor for your tax questions. Call SPSP/401(k) Participant Services for more information.

Other Items to Remember

- Be sure to keep your beneficiary current with Wachovia using the on-line system at Wachovia.com/myretireplan.
- Be sure to keep your address current with the Personnel Department.

NOTE: If you want to save additional monies on a pre-tax basis, you may want to consider having contributions made to the Deferred Compensation Plan through payroll deductions. You may contribute an additional \$16,500 to \$22,000 depending on your age and up to \$33,000 if you have not contributed the maximum each year of employment. Additional information may be obtained by contacting the Employee Savings Plans Office at (619) 236-6600 or the VALIC representative at (800-892-5558, ext. 89330 or 89365).

See Appendix I for a comparison of the 401(k) and Deferred Compensation Plans.

CASH PAYMENT

TAXABLE BENEFIT

After you have decided and “bought” your benefits on the 2009-2010 Flexible Benefits Worksheet, you may designate any remaining flexible benefits dollars as cash. This benefit will be taxed at your normal withholding rate.

This cash income will be reported on your W-2 form in the calendar year you receive it.

You earn the cash payment benefit only when in a pay status (including Industrial Leave and Long-Term Disability). If you are on a Leave Without Pay or other unbenefitted status including working less than 40 hours in a pay period, amounts will not accrue to this option.

This benefit is not carried forward into the subsequent benefit year.

No reimbursement claim forms are required for this option. You will receive the biweekly amount each pay period you are eligible automatically on your paycheck for that pay period.

CONTINUATION OF COVERAGE

HOW TO CONTINUE YOUR MEDICAL INSURANCE PARTICIPATION

Continuation of Coverage (COBRA)

How to Continue Your Medical Insurance Participation

It is important that all covered individuals (employee, spouse, and dependent children) take the time to read this notice carefully and be familiar with its contents. If there is a covered dependent not living at your current address, please provide Flexible Benefits Plan Section with the appropriate address so that a notice can be sent to them as well.

Under a federal law commonly known as COBRA, the City of San Diego is required to offer you, your spouse and dependent children the opportunity to temporarily continue medical coverage at group rates where coverage under the plan would otherwise be reduced or terminated because of certain life events

(known as a “qualifying events”, which are described in more detail later in this notice). Individuals entitled to COBRA continuation coverage (known as “qualified beneficiaries”) are you, your spouse and dependent children who are covered under the plan at the time of a qualifying event. In addition, a child who is born to you or adopted or placed for adoption with you during the COBRA coverage period is also a qualified beneficiary.

This notice is simply intended to inform you (and your covered dependents, if any), in a summary fashion of your potential future options and obligations under COBRA. Should an actual qualifying event occur in the future, Flexible Benefits Plan Section will send you the appropriate notification. **Please take special note, however, of your notification obligations which are highlighted in this notice.**

The tables below and on the next page provides a summary of the COBRA provisions outlined in this section.

Qualifying Events That Result in Loss of Coverage	Maximum Continuation Period		
	Employee	Spouse	Child
Employee's work hours are reduced and results in loss of coverage	18 months	18 months	18 months
Employee terminates employment for any reason (other than gross misconduct)	18 months	18 months	18 months
Employee becomes entitled to Medicare as a retiree	N/A	36 months	36 months
Employee or dependent is disabled (as determined by the Social Security Administration) at the time of the qualifying event or becomes disabled within the first 60 days of COBRA continuation that begins as a result of termination or reduction in work hours	29 months	29 months	29 months
Employee dies	N/A	36 months	36 months
Employee and spouse legally separate or divorce	N/A	36 months	36 months
Employee becomes entitled to Medicare within 18 months prior to termination of employment or reduction in work hours	N/A	36 months*	36 months*
Child no longer qualifies as a dependent	N/A	N/A	36 months

* 36-month period is counted from the date you become entitled to Medicare.

Qualifying Events That Result in Loss of Coverage	Maximum Continuation Period		
	Employee	Spouse	Child
For medical coverage only, after initial 18-month federal COBRA coverage (caused by termination of employment or reduction in work hours) has been exhausted, an employee and covered dependents are entitled to Cal-COBRA extended coverage.	18 months	18 months	18 months

Qualifying Events

If your employment terminates for any reason other than your gross misconduct or if your hours worked are reduced so that your plan coverage terminates, you, your covered spouse and dependent children may continue medical coverage under the plan for up to 18 months.

If you should die, become legally separated or divorced, or become entitled to Medicare as a retiree, your covered dependents whose medical coverage under the plan would be reduced or terminated may continue medical coverage under the plan for up to 36 months. Also, your covered children may continue medical coverage for up to 36 months after they no longer qualify as covered dependents under the terms of the plan.

Certain events may extend an 18-month COBRA continuation period applicable to your termination of employment or reduction in hours worked:

- If your dependents experience a second qualifying event within the original 18-month period, they (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event).
- If you (the employee) became entitled to Medicare while employed (even if it was not a qualifying event for your covered dependents because their coverage was not lost or reduced) and then a second qualifying event (such as your termination of employment or reduction in hours of work) happens within 18 months, your dependents may elect COBRA continuation for up to 36 months from the date you became entitled to Medicare.

- If you or your dependent is disabled (as determined by the Social Security Administration) on the date of a termination of employment or reduction in work hours or at any time during the first 60 days of COBRA continuation coverage due to such event, each qualified beneficiary (whether or not disabled) may extend COBRA continuation coverage for up to an additional 11 months (for a total of up to 29 months). To qualify for this disability extension, Risk Management – Benefits Division must be notified of the person's disability status both within 60 days after the Social Security disability determination is issued and before the end of the original 18-month COBRA continuation period. Also, if Social Security determines that the qualified beneficiary is no longer disabled, you are required to notify Risk Management – Benefits Division within 30 days after this determination.
- Upon completion of the original 18-month COBRA continuation period you and your covered dependents may extend the period for an additional 18-month period under California COBRA. Your insurer will provide you notice of your extension rights prior to your original COBRA ending.

IMPORTANT NOTE: If a second qualifying event occurs at any time during this 29-month disability continuation period, then each qualified beneficiary who is a spouse or dependent child (whether or not disabled) may further extend COBRA coverage for seven more months, for a total of up to 36 months from the termination of employment or reduction in hours of employment.

Giving Notice That a COBRA Event Has Occurred

To qualify for COBRA continuation upon legal separation, divorce or loss of your child's dependent status under the plan, you or one of your dependents MUST notify Flexible Benefits Plan Section of the legal separation, divorce or loss of dependent status within 60 days of the later of the date of the event or the date the individual would lose coverage under the plan. Your covered dependents then will be provided with instructions for continuing your medical coverage. Individuals already on COBRA continuation must notify Flexible Benefits Plan Section within these deadlines if a legal separation, divorce or loss of a child's dependent status occurs that would extend the period of COBRA coverage for your spouse or dependent child(ren). Carefully read the dependent eligibility rules contained in the Flexible Benefits Summary Highlights. To delete an eligible dependent, complete the appropriate Family Account change form available on the intranet or from your payroll specialist and submit it to Flexible Benefits Plan Section (their address is located at the end of this notice). If this notification is not completed in a timely manner, then rights to COBRA continuation coverage may be forfeited.

For other qualifying events (i.e., if your employment ends, your hours are reduced, you become entitled to Medicare, or you die), the City of San Diego has the responsibility to notify Flexible Benefits Plan Section of the qualifying event, and Flexible Benefits staff will then provide you and/or your covered dependents with instructions for continuing medical coverage.

Electing and Paying for COBRA Continuation Coverage

You and/or your covered dependents must choose to continue coverage within 60 days after the later of the following dates:

- The date you and/or your covered dependents would lose coverage as a result of the qualifying event
- The date Risk Management – Benefits Division notifies you and/or your covered dependents of your right to choose to continue coverage as a result of the qualifying event.

Premium Due Date: If you elect COBRA continuation coverage, you must pay the initial premium (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA premiums must be paid monthly and within 30 days of each due date. If you elect COBRA continuation but then fail to pay the premium due within the initial 45-day grace period, or you fail to pay any subsequent premium within 30 days after the date it is due, your coverage will be terminated retroactively to the last day for which timely payment was made.

Cost

Continuing Active or Retiree Coverage: The cost of COBRA coverage is 102% of the full cost of plan coverage.

Additional Cost Requirements for Continuation of Active Coverage Only: The cost of coverage for the 19th through 29th months of coverage under the disability extension is 1) 150% of the full cost of coverage for all family members participating in the same coverage option as the disabled individual, and 2) 102% for any family members participating in a different coverage option than the disabled individual, except as provided below.

If a second qualifying event occurs during the first 18 months of coverage, the 102% rate applies to the full 36 months even if the individual is disabled. However, if a second qualifying event occurs during the otherwise applicable disability extension period (that is, during the 19th through 29th month), then the rate for the 19th through 36th months of the COBRA continuation period is 1) the 150% rate for all family members participating in the same coverage option as

the disabled individual, and 2) the 102% rate for any family members in a different coverage option than the disabled individual.

The cost for Cal-COBRA extended coverage beyond the original 18-month COBRA continuation period without a secondary qualifying event is generally 110% of the full cost of plan coverage.

Coverage During the Continuation Period

If coverage under the plan is changed for active employees, the same changes will be provided to individuals on COBRA continuation. Qualified beneficiaries also may change their coverage elections during the annual enrollment periods, if a change in status occurs, or at other times under the plan to the same extent that similarly situated non-COBRA employees or retirees may do so.

When COBRA Continuation Coverage Ends

COBRA continuation of medical coverage for any person will end when the first of the following occurs:

- The applicable continuation period ends.
- The initial premium for continued coverage is not paid within 45 days after the date COBRA is elected, or any subsequent premium is not paid within 30 days after it is due.
- After the date COBRA is elected, the qualified beneficiary first becomes covered (as an employee or otherwise) under another group medical plan not offered by the City of San Diego, and the other plan does not contain an exclusion or limitation affecting the person's preexisting condition, or the other plan's preexisting condition limit or exclusion does not apply or is satisfied because of the HIPAA rules.
- After the date COBRA is elected, the qualified beneficiary first becomes entitled to Medicare. (This does not apply to other qualified beneficiaries who are not entitled to Medicare.)
- In the case of the extended coverage period due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months.

- For newborns and children adopted by or placed for adoption with you (the employee) during your COBRA continuation period, the date your COBRA continuation period ends unless a second qualifying event has occurred.
- The City of San Diego terminates all group medical coverage for all employees and retirees.
- A qualified beneficiary notifies Risk Management – Benefits Division that they wish to cancel COBRA coverage.

When your COBRA coverage terminates, you may be able to convert your coverage to individual, nonplan coverage under the plan's conversion rights feature. Contact Risk Management – Benefits Division for further details.

Notification of Address Change

To ensure that all covered individuals receive information properly and efficiently, it is important that you notify your payroll specialist of any address change as soon as possible. Failure on your part to do so may result in delayed notifications or a loss of COBRA coverage options.

Any Questions

If a covered individual does not understand any part of this summary notice or has questions regarding the information or your obligations, please contact the Flexible Benefits Plan Section, 1200 Third Avenue, Suite 1000, San Diego, CA 92101, (619) 236-5924.

NOTICE OF PRIVACY PRACTICES

FROM YOUR GROUP MEDICAL PLAN

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As we work every day to provide your benefits and pay your claims, protecting the confidentiality of personal medical information has always been an important priority. We (The City of San Diego Employees' Flexible Benefits Plan) are adopting new policies to safeguard the privacy of your medical information and comply with federal law (specifically, the Medical Insurance Portability and Accountability Act, known as "HIPAA").

Note: If you are covered by an insured medical option under the Plan (e.g., Kaiser, HealthNet, Sharp), you will also receive a separate notice from your medical plan insurer or HMO.

In this notice we want to help you understand:

- How your personal medical information may be used, and
- What rights you have regarding this information.

How The Group Medical Plan May Use Your Information

In order to manage your medical plan effectively, we are permitted by law to use and disclose your personal medical information (called "Protected Medical Information") in certain ways, without your authorization:

For treatment. So that you receive the right treatment and care, your Protected Medical Information may be used as providers coordinate or manage your medical care services. For example, your physician uses your information when he or she consults with a specialist regarding your condition.

For payment. To make sure that claims are paid correctly and you receive the benefits you are entitled to, we may use and disclose your Protected Medical Information to determine plan eligibility and responsibility for coverage and benefits. For example, we may use your information when we confer with other medical plans to resolve a coordination of benefits issue.

For medical care operations. To ensure quality and efficient plan operations, we may use your Protected Medical Information in a number of ways, including plan administration, quality assessment and improvement, and vendor review. Your information could be used, for example, to assist in the evaluation of a vendor who supports us, or we may contact you to provide reminders or information about treatment alternatives or other medical-related benefits and services available under the Plan.

We may also disclose your Protected Medical Information to City of San Diego (the plan sponsor) in connection with these activities. If you are covered under an insured medical plan, the insurer also may disclose Protected Medical Information to the plan sponsor in connection with payment, treatment or medical care operations.

Other Permitted Uses and Disclosures

Federal regulations allow use and disclosure of your Protected Medical Information, without your authorization, for several additional purposes:

- Public medical activities
- Disclosures to an appropriate government authority regarding victims of abuse, neglect or domestic violence
- Oversight activities of a medical oversight agency authorized by law
- Judicial and administrative proceedings
- Law enforcement activities
- To a coroner or medical examiner
- To cadaveric organ, eye or tissue donation programs
- Research purposes, as long as certain privacy-related standards are satisfied
- To avert a serious threat to medical or safety
- Specialized government functions (e.g., Military and veterans' activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations)

- Workers' compensation or similar programs that provide benefits for work-related injuries or illness
- Other purposes required by law, provided that the use or disclosure is limited to the relevant requirements of such law.

In Special Situations...

We may disclose your Protected Medical Information to a family member, relative, close personal friend, or any other person whom you identify, when that information is directly relevant to the person's involvement with your care or payment related to your care.

We may use your Protected Medical Information to notify a family member, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location, general condition, or death.

If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to agree to or object to this use or disclosure, we will do what in our judgment is in your best interest regarding such disclosure and will disclose only information that is directly relevant to the person's involvement with your medical care.

Other uses and disclosures will be made only after you authorize them in writing. You may revoke your authorization in writing at any time.

Your Rights Regarding Protected Medical Information

You may ask us to restrict how we use and disclose your Protected Medical Information as we carry out treatment, payment, or medical care operations. You may also ask us to restrict disclosures to your family members, relatives, friends, or other persons you identify who are involved in your care or payment for your care. However, we are not required to agree to these requests.

You also have the right to request:

- Inspection and copying of your Protected Medical Information
- Amendment or correction of inaccurate information

- An accounting of certain disclosures made by us (However, you are not entitled to an accounting of disclosures made for payment, treatment or medical care operations, or disclosures you authorized in writing.)
- A paper copy of this notice.

You have the right to request that you receive your Protected Medical Information by alternative means or at an alternative location if you reasonably believe that other disclosure could pose a danger to you. For example, you may only want to have information sent by mail or to a work address.

For more information about exercising these rights, contact the office identified at the end of this notice.

About This Notice

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all Protected Medical Information we maintain. If we change this notice, you will receive a new notice by mail.

If you believe that your privacy rights have been violated, you may file a written complaint without fear of reprisal. Your complaint should be directed to the location identified below under "Contacting Us" or, if in California, to Region IX, Office for Civil Rights, Department of HHS, 50 United Nations Plaza, Room 322, San Francisco, CA 94102.

Contacting Us

You may exercise the rights described in this notice by contacting The City of San Diego office identified below, which will provide you with additional information. The contact is:

Privacy Officer
The City of San Diego Flexible Benefits Plan
1200 3rd Avenue, Suite 1000
San Diego, CA 92101
Telephone: 619-236-5924
FAX: 619-533-4077

Effective date of notice: April 14, 2003

NOTICE OF MEDICARE AND PRESCRIPTION DRUG COVERAGE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The City of San Diego and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of San Diego has determined that the prescription drug coverage offered by HealthNet Kaiser, and/or Sharp Health plans is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage. Any employee enrolled in one of these plans that is eligible for Medicare is enrolled in a Part D plan through the medical plan and should not enroll for a separate Medicare prescription drug plan. If you do you will be disenrolled from the City sponsored medical coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in another Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan outside of the City's medical plan you are enrolled in, you will be dropped from the City's medical plan.

You should also know that if you drop or lose your coverage with the City of San Diego and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage contact Risk Management-Benefits at 619-236-5924.

NOTE: You will receive this notice annually and if this coverage through the City of San Diego changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: June 2009

Name of Entity/Sender: The City of San Diego

Contact–Position/Office: Valerie VanDeweghe, Benefits Manager

Address: 1200 3rd Avenue, Ste 1000, San Diego, CA 92101

Phone Number: 619-236-5924

ADDITIONAL INFORMATION

FACTS YOU SHOULD KNOW ABOUT YOUR PLAN

Your Rights as a Plan Participant

As a participant in the Plan, you are entitled to certain rights. You may:

- examine, without charge, all plan documents (including insurance contracts)
- obtain copies of those plan documents at a reasonable cost
- obtain other Plan information upon request to the Plan Administrator (see THE PLAN ADMINISTRATOR section in this handbook for the address and telephone number).

Available Brochures and Applications

The information in this handbook is summarized for your convenience. Your Payroll Specialist has brochures and applications which describe, in detail, the following options:

HealthNet Health Insurance

Kaiser Health Insurance

Sharp Health Insurance

Life Insurance

Dental: United Concordia DHMO

Dental: United Concordia DPO

Vision: Blue Shield of CA/MESVision

In addition, these applications will be made available during your open enrollment period:

Local 127 Dental: Metlife/Safeguard DHMO

Local 127 Dental: Metlife/Safeguard PPO

MEA Sharp Health Plan

MEA Dental: DeltaCare DHMO

MEA Dental: Delta PPO

MEA Vision: EyeMed Vision

Changing or Ending the Plan

The City reserves the right to change the Plan from time to time in order to meet the requirements of Federal law or changes brought about through negotiations with Employee Groups. In no event will the Plan be amended so that your contributions or benefit payments go to pay for anything but your benefits under this Plan.

The City also reserves the right to end the Plan, subject to negotiations with Employee Groups. The date the Plan would end must be agreed upon by the City and the Employee Groups. In no event will the funds used to provide benefits for you and your family be returned to the City. These funds must be used to provide benefits for you and your family only.

The Plan Administrator

The Employee Benefits Division of the Risk Management Department is the Plan Administrator. The Plan Administrator's primary responsibility is to manage the Flexible Benefits Plan according to the terms of the Plan Document. The Plan Administrator reserves the right to determine eligibility and construe the terms of the Plan, subject to the collective bargaining agreements in effect.

If you have any questions about the Flexible Benefits Plan, you should call or write the Risk Management Department at:

1200 Third Avenue, Suite 1000
San Diego, CA 92101
(619) 236-5924

APPENDIX A

FPB ALLOTMENT

	ANNUAL	BIWEEKLY (26 Pay Periods)
MEA represented employees	\$ 6,075	\$ 233.65
Local 127 represented employees with Medical coverage	\$ 5,575	\$ 214.42
Local 127 represented employees Waiving Medical coverage	\$ 4,575	\$ 175.96
POA represented employees*		
No Medical coverage	\$ 1,500	\$ 57.69
Employee only	\$ 3,837	\$ 147.57
Employee & Children	\$ 5,814	\$ 223.61
Employee & Spouse/Domestic Partner	\$ 6,280	\$ 241.53
Employee & Spouse/Domestic Partner & Children	\$ 7,588	\$ 291.84
Local 145 represented employees*		
No Medical coverage	\$ 1,750	\$ 67.30
Employee only	\$ 4,750	\$ 182.69
Employee & Children	\$ 7,225	\$ 277.88
Employee & Spouse/Domestic Partner	\$ 7,800	\$ 300.00
Employee & Spouse/Domestic Partner & Children	\$ 9,400	\$ 361.53
DCAA represented employees*		
No Medical coverage	\$ 3,220	\$ 123.84
Employee only	\$ 6,921	\$ 266.19
Employee & Children	\$ 9,346	\$ 359.46
Employee & Spouse/Domestic Partner	\$ 10,432	\$ 401.23
Employee & Spouse/Domestic Partner & Children	\$ 10,799	\$ 415.34
Unrepresented and Unclassified employees*		
No Medical coverage	\$ 4,500	\$ 173.07
Employee only	\$ 7,701	\$ 296.19
Employee & Children	\$ 10,126	\$ 389.46
Employee & Spouse/Domestic Partner	\$ 10,699	\$ 411.50
Employee & Spouse/Domestic Partner & Children	\$ 12,294	\$ 472.84

APPENDIX B

MEDICAL BENEFIT PLANS COSTS

You may use your annual allotment to “buy” coverage for you and/or your dependents at the “prices” shown below. If the amount exceeds the Annual Allotment the remainder of the cost will be deducted from your paycheck every pay period.

	BIWEEKLY (26 PAY PERIODS)	MONTHLY	ANNUAL
Kaiser			
Employee only	\$ 141.73	\$ 307.05	\$ 3,685
Employee & Spouse/Domestic Partner	\$ 310.35	\$ 672.41	\$ 8,069
Employee & Children	\$ 269.26	\$ 583.38	\$ 7,001
Employee & Spouse/Domestic Partner & Children	\$ 430.81	\$ 933.41	\$ 11,201
COSD Sharp			
Employee only	\$ 160.73	\$ 348.25	\$ 4,179
Employee & Spouse/Domestic Partner	\$ 352.00	\$ 762.66	\$ 9,152
Employee & Children	\$ 305.38	\$ 661.66	\$ 7,940
Employee & Spouse/Domestic Partner & Children	\$ 488.62	\$ 1,058.66	\$ 12,704
Health Net HMO			
Employee only	\$ 202.03	\$ 437.74	\$ 5,253
Employee & Spouse/Domestic Partner	\$ 442.43	\$ 958.58	\$ 11,503
Employee & Children	\$ 383.84	\$ 831.66	\$ 9,980
Employee & Spouse/Domestic Partner & Children	\$ 614.15	\$ 1,330.66	\$ 15,968
Health Net PPO			
Employee only	\$ 347.19	\$ 752.22	\$ 9,027
Employee & Spouse/Domestic Partner	\$ 760.31	\$ 1,647.33	\$ 19,768
Employee & Children	\$ 659.62	\$ 1,429.16	\$ 17,150
Employee & Spouse/Domestic Partner & Children	\$ 1,055.42	\$ 2,286.71	\$ 27,441
MEA Sharp Classic HMO*			
Employee only	\$ 162.00	\$ 351.00	\$ 4,212
Employee & Spouse/Domestic Partner	\$ 354.92	\$ 768.99	\$ 9,228
Employee & Children	\$ 307.85	\$ 666.98	\$ 8,004
Employee & Spouse/Domestic Partner & Children	\$ 492.00	\$ 1,066.00	\$ 12,792
MEA Sharp Value HMO*			
Employee only	\$ 143.08	\$ 309.98	\$ 3,720
Employee & Spouse/Domestic Partner	\$ 312.00	\$ 676.00	\$ 8,112
Employee & Children	\$ 270.92	\$ 586.99	\$ 7,044
Employee & Spouse/Domestic Partner & Children	\$ 432.92	\$ 937.99	\$ 11,256
Waiver**	\$ 0.69	\$ 1.50	\$ 18

* MEA represented employees only.

** The Waiver cost only applies for MEA and Local 127 represented employees.

APPENDIX C

BASIC LIFE INSURANCE PREMIUMS

BASIC TERM LIFE INSURANCE WITH AD&D – FOR MEA AND LOCAL 127 CLASSIFICATIONS ONLY

AMOUNT OF INSURANCE	\$10,000	\$25,000	\$50,000
(City Paid) Annual Value	\$11	\$27	\$53

PORTABLE TERM WITH AD&D LIFE INSURANCE Newly hired employees applying for Portable term life coverage within the first 30 days of employment or the first open enrollment thereafter may receive up to the designated amount listed below by completing an enrollment form.

(Employee Paid)

Guaranteed Issue

To age 60	:	\$250,000
60+	:	\$50,000

A spouse/domestic partner of newly hired employees may receive \$50,000 of coverage by completing an enrollment form.

If you are applying for more than the “guaranteed issue” amount described above, answer yes to the health questions or are not a new employee but applying for this coverage for the first time, you must also complete and sign the Proof of Good Health form. Coverage and payroll deductions will not begin until approval has been given by ReliaStar Life.

EMPLOYEE OR SPOUSE OR DOMESTIC PARTNER PORTABLE TERM LIFE						
AGE	AMOUNT OF INSURANCE – BIWEEKLY (26 PP) PREMIUM					
	\$25,000	\$50,000	\$75,000	\$100,000	\$150,000	\$200,000
Under 25	0.58	1.16	1.74	2.31	3.47	4.62
25 - 29	0.70	1.39	2.08	2.77	4.16	5.54
30 - 34	0.93	1.85	2.77	3.70	5.54	7.39
35 - 39	1.04	2.08	3.12	4.16	6.24	8.31
40 - 44	1.27	2.54	3.81	5.08	7.62	10.16
45 - 49	1.74	3.47	5.20	6.93	10.39	13.85
50 - 54	2.89	5.77	8.66	11.54	17.31	23.08
55 - 59	5.20	10.39	15.58	20.77	31.16	41.54
60 - 64	8.08	16.16	24.24	32.31	48.47	64.62
65 - 69	15.58	31.16	46.74	62.31	93.47	124.62
70 and Over	27.70	55.39	83.08	110.77	166.16	221.54
AGE	AMOUNT OF INSURANCE – BIWEEKLY (26 PP) PREMIUM					
	\$250,000	\$300,000	\$350,000	\$400,000	\$450,000	\$500,000
Under 25	5.77	6.93	8.08	9.24	10.39	11.54
25 - 29	6.93	8.31	9.70	11.08	12.47	13.85
30 - 34	9.24	11.08	12.93	14.77	16.62	18.47
35 - 39	10.39	12.47	14.54	16.62	18.70	20.77
40 - 44	12.70	15.24	17.77	20.31	22.85	25.39
45 - 49	17.31	20.77	24.24	27.70	31.16	34.62
50 - 54	28.85	34.62	40.39	46.16	51.93	57.70
55 - 59	51.93	62.31	72.70	83.08	93.47	103.85
60 - 64	80.77	96.93	113.08	129.24	145.39	161.54
65 - 69	155.77	186.93	218.08	249.24	280.39	311.54
70 and Over	276.93	332.31	387.70	443.08	498.47	553.85

*Age will be automatically reviewed by the payroll computer system each pay period. Any premium increase resulting from age change will be made automatically by the payroll computer system.

APPENDIX C CONTINUED

Internal Revenue Code Section 79 requires that participants in this plan receive imputed income in instances where the plan rate is more favorable than the mortality rate used in IRC Section 79. Imputed income is typically added to taxable wages through an adjustment to the form W-2.

If you or your spouse/domestic partner are enrolled, you may also add coverage for your child(ren). Children can only be covered once.

		Deduction per pay period
		(regardless of number of children covered)
Coverage amount per child	\$ 5,000**	\$ 0.52
Coverage amount per child	\$10,000**	\$ 0.62

**No coverage for children less than 14 days old. Coverage for children 14 days to 6 months of age is limited to 10% of policy amount.

APPENDIX D

DENTAL AND VISION COSTS

DENTAL INSURANCE			
	BIWEEKLY (26 PAY PERIODS)	MONTHLY	ANNUAL
Concordia Dental DHMO*			
Employee only	\$ 5.88	\$ 12.72	\$ 153
Employee & Spouse/Domestic Partner	\$ 11.73	\$ 25.40	\$ 305
Employee & Children	\$ 10.26	\$ 22.24	\$ 267
Employee & Spouse/Domestic Partner & Children	\$ 18.19	\$ 39.40	\$ 473
Concordia Dental DPO*			
Employee only	\$ 20.00	\$ 43.28	\$ 520
Employee & Spouse/Domestic Partner	\$ 39.96	\$ 86.54	\$ 1,039
Employee & Children	\$ 38.96	\$ 84.38	\$ 1,013
Employee & Spouse/Domestic Partner & Children	\$ 61.73	\$ 133.72	\$ 1,605
MEA Delta DHMO**			
Employee only	\$ 7.84	\$ 16.98	\$ 204
Employee & Spouse/Domestic Partner	\$ 15.69	\$ 33.99	\$ 408
Employee & Children	\$ 15.69	\$ 33.99	\$ 408
Employee & Spouse/Domestic Partner & Children	\$ 22.61	\$ 48.98	\$ 588
MEA Delta DPO**			
Employee only	\$ 26.30	\$ 56.98	\$ 684
Employee & Spouse/Domestic Partner	\$ 50.76	\$ 109.98	\$ 1,320
Employee & Children	\$ 58.61	\$ 126.98	\$ 1,524
Employee & Spouse/Domestic Partner & Children	\$ 85.38	\$ 184.99	\$ 2,220
Local 127 Metlife/Safeguard DHMO***			
Employee only	\$ 9.30	\$ 20.10	\$ 242
Employee & 1 Dependent	\$ 16.38	\$ 35.50	\$ 426
Employee & 2 or more Dependents	\$ 22.96	\$ 49.68	\$ 597
Local 127 Metlife/Safeguard DPO***			
Employee only	\$ 19.34	\$ 41.90	\$ 503
Employee & 1 Dependent	\$ 38.46	\$ 83.30	\$ 1,000
Employee & 2 or more Dependents	\$ 69.76	\$ 151.14	\$ 1,814

* POA, Local 145, Unrepresented and Unclassified employees only

** MEA represented employees only

*** Local 127 represented employees only

APPENDIX D CONTINUED

DENTAL AND VISION COSTS

VISION INSURANCE			
	BIWEEKLY (26 PAY PERIODS)	MONTHLY	ANNUAL
Blue Shield of California/MES*			
Employee only	\$ 2.80	\$ 6.06	\$ 73
Employee & Spouse/Domestic Partner	\$ 5.60	\$ 12.12	\$ 146
Employee & Children	\$ 4.90	\$ 10.61	\$ 128
Employee & Spouse/Domestic Partner & Children	\$ 8.79	\$ 19.04	\$ 229
MEA Eyemed**			
Employee only	\$ 7.38	\$ 15.99	\$ 192
Employee & Spouse/Domestic Partner	\$ 12.69	\$ 27.49	\$ 330
Employee & Children	\$ 13.15	\$ 28.49	\$ 342
Employee & Spouse/Domestic Partner & Children	\$ 21.69	\$ 46.99	\$ 564

* MEA represented employees not eligible

** MEA represented employees only

APPENDIX E

FREQUENTLY ASKED QUESTIONS

1. WHAT DO I HAVE TO DO TO GET MY MONEY?

CASH PAYMENTS – Payments are included on your paycheck biweekly.

DENTAL/MEDICAL/VISION AND DEPENDENT/CHILD CARE REIMBURSEMENTS – Payroll Specialists have a supply of claim forms. Claim forms are also available on the intranet or the Flexible Benefits Plan Section. Complete the employee portion, be sure to date and sign, and send the claim reimbursement form along with your receipt to Flexible Benefits Plan Section – MS 51E.

2. WHY ARE TAXES TAKEN OUT OF THE CASH PAYMENT OPTION?

This is a taxable benefit and tax withholding is required by the IRS.

3. WHY DO I HAVE TO USE THE MONEY FOR REIMBURSABLE OPTIONS BY JUNE 30TH?

The IRS does not allow the “rolling over” of benefits from one benefit year to the next. To do so would disqualify this program. The City wants employees to make selections from which they will get the most value. The City reminds employees that this benefit is a use or lose option.

4. WHAT DOES “ACCRUE” MEAN?

The term accrue simply means accumulate (gradually build). Each pay period if an employee is in a benefitted status (working), an equal portion of the total annual allotment will be placed into the employee’s account to be paid at the designated reimbursement time.

5. WHEN CAN I MAKE CHANGES IN MY FLEXIBLE BENEFITS?

IRS guidelines state that no benefit selection changes can be made after the plan year begins (July 1). IRS makes an exception to the rule should any of the following occur: marriage, divorce, legal separation or annulment; death of the spouse or dependent; birth or adoption of child; a change in coverage due to a spouse’s or dependent’s employment (including a spouse’s open enrollment), or certain other events allowed by the IRS. Should one of these situations occur and you would like to change your current elections contact Flexible Benefits Plan Section to complete the necessary paperwork. **The change must be requested within 30 days of the change in status.**

6. WHEN CAN I ADD DEPENDENTS TO MY HEALTH PLAN?

New dependents can be added during the year; however, they must be added within 30 days of becoming a dependent by marriage, birth, or adoption. Dependents can be deleted at any time, but Flexible Benefit dollars cannot be changed unless there is a qualified event as described in #5. If you have questions, please contact Flexible Benefits Plan Section, (619) 236-5924.

7. CAN I PURCHASE PORTABLE TERM LIFE INSURANCE DURING THE YEAR?

Yes. You can add or delete this payroll deduction at anytime during the year. Adding or increasing this insurance is subject to approval by the life insurance carrier.

8. DO I KEEP MY FLEXIBLE BENEFITS WHEN I RETIRE?

No. Flexible Benefits are only for active City employees working in a benefit status.

9. CAN I SUPPLEMENT MY FLEXIBLE BENEFIT ALLOTMENT THROUGH PAYROLL DEDUCTION OR A CASH PAYMENT?

Yes. If you don’t have enough Flexible Benefit allotment to buy all the benefits you would like, you can pay the difference from your paycheck.

APPENDIX F

ALLOWABLE MEDICAL EXPENSES

The Internal Revenue Service has issued a complete list of eligible expenses for Section 125 reimbursement accounts. Below is a list of the most common items for which an employee can receive medical reimbursement. Of course, for expenses also covered under group health plans, employees can only be reimbursed for the amount they incurred “out of pocket” due to deductibles, co-payments or charges over any policy limitations.

Fees and Services

Abortions, legal
Ambulance Hire
Anesthesiologist
Care for the Mentally Handicapped
Chiropractic Care
Devices (medically necessary)
Christian Science Practitioners Fees
Dermatologist Fees*
Education for the Blind
Fees for Healing Services
Hospital Fees
Hypnosis for Treatment of an Illness
Laboratory Fees
Medical Information Plan
Nursing Care
Obstetrical Expenses
Physical/Mental Illness Confinement
Physician Fees
Practical Nurse Fees
Psychiatric Care
Psychologist Fees
Schools for the Mentally Handicapped
Sterilization Fees
Surgical and Diagnostic Fees

Medical Equipment

Artificial Limbs
Car Controls for the Handicapped
Communication Equipment for the Deaf
Crutches
Hearing Aids/Batteries
Orthopedic Shoes
Oxygen Equipment
Wheelchairs
Wigs (for hair loss due to medical reasons)

Dental and Orthodontic Care

Artificial Teeth
Braces, Orthodontic*
Dental Fees
Dentures

Physical Examinations

Routine and Preventive Physicals
School and Work Physicals

Vision Care

Braille Books and Magazines (cost in excess of regular printed materials)
Optometrist's Fees
Ophthalmologist's Fees
Seeing-eye Dog and Its Care

Therapy/Treatment

Acupuncture
Special Diets*
Speech Therapy
Treatment for Alcoholism or Drug Addiction
Vaccinations
X-Ray Treatments

Prescription Drugs

Birth Control Pills
Laetrile by prescription
Prescription Drugs or Insulin
Vitamins by prescription (dispensed by pharmacist)

A Note About Over-the-Counter (OTC) Medications

The Plan allows reimbursement for over-the-counter medications. Generally, OTC medications that are used to treat a medical condition, such as hay fever, headaches, and flu, are eligible expenses. But over-the-counter items intended for general health and well-being – such as vitamins, herbal supplements, toothpaste, dietary supplements, and cosmetics – are not eligible for reimbursement. However, you can provide a doctor's note with your claim to show that something normally thought of as simply for "general health" is actually needed to treat a specific medical condition. This note (plus appropriate receipt) can allow you to receive reimbursement from the DMV Reimbursement account.

Examples of over-the-counter medications that will generally be considered eligible expenses:

- Allergy medicine
- Antacid
- Anti-diarrhea medicine & laxatives
- Band-Aids, bandages & gauze pads
- Calamine lotion
- Carpal tunnel wrist support
- Cold & flu medicine
- Cold/hot packs for injuries
- Contact lens cleaning and wetting solution
- Cough drops & throat lozenges
- First aid cream & antibacterial ointment
- Menstrual cycle products for pain & cramp relief
- Motion sickness pills
- Muscle or joint pain reliever
- Nicotine gum or patches for smoking cessation
- Ointment or cream for sunburn
- Pain reliever
- Reading glasses
- Sinus medication & nasal sinus sprays
- Suppositories and creams for hemorrhoids
- Wart removal treatment

Examples of over-the-counter medications that will require a doctor's note which includes diagnosis of a specific medical condition to be treated:

- Acne treatment
- Arthritis treatments such as Glucosamine/Chondroitin
- Chinese herbs, naturopathic, & dietary supplements
- Depression medication
- Hormone therapy
- Lactose intolerance pills
- Nasal spray for snoring
- Orthopedic shoes and inserts (price difference only)
- Prenatal vitamins
- Retin A for non-cosmetic purpose
- Rogaine for non-cosmetic purpose
- Sleeping aids
- Sunscreen
- Topical creams
- Vitamins (to treat a medical condition)
- Weight loss drugs

Examples of ineligible expenses:

- Chapstick
- Cosmetics
- Deodorant
- Face cream, suntan lotion, & moisturizers
- Illegal treatments
- Medicated shampoo & soap
- Mouthwash
- NoDoz
- One-a-day vitamins
- Sleeping pills
- Tissues
- Toiletries
- Toothbrush and toothpaste
- Vacuum cleaners
- Vaseline

Over-the-counter drug purchases must be limited to a reasonable supply.

When submitting claims for over-the-counter items, you will need to supply a cash register receipt that clearly shows the item purchased. A receipt which lists only a price is not sufficient.

APPENDIX G

QUESTIONS AND ANSWERS ABOUT YOUR REIMBURSEMENT ACCOUNTS

Q. How do I decide how much money to put into a Dental/Medical/Vision or a Dependent Care Reimbursement Account?

To establish either a Dental/Medical/Vision Account or a Dependent Care Reimbursement Account, you may set aside up to \$5,000 per account for a Plan Year (July 1 to June 30). Your biweekly contribution could range from \$1.00 to \$192.30. To the best of your ability, you must estimate the kinds of health care and dependent care expenses your family is likely to have that are not covered by your benefit options.

Q. Can I transfer money from my Dental/Medical/Vision Reimbursement Account to my Dependent Care Reimbursement Account or vice-versa?

No. Because of IRS regulations, each account is set up separately and the funds cannot be mixed.

Q. May I make a lump sum contribution to my Reimbursement Accounts?

No. Contributions to Reimbursement Accounts are made in the form of biweekly payroll deductions and/or Flexible Benefits contributions.

Q. What happens to my Reimbursement Accounts if I leave my job mid-year?

You cannot cash out your account. However, you may submit claims up to 30 days after termination for expenses you incurred while eligible for the reimbursement option. An option to continue coverage (by paying monthly premiums directly to the Plan) is also available.

Q. May I deduct any forfeited funds on my income tax return?

No. Forfeitures are not deductible because you already reduced your taxable income by placing the pre-tax dollars in your account.

Q. How do I submit a claim for reimbursement from my Reimbursement Accounts?

You must fill out a Reimbursement Claim Form and submit it to the Employee Benefits Division of the Risk Management Department. Proof that the doctor provided the services you want reimbursed is also required. Claim forms are available through your department Payroll Specialist or on the intranet under the Pay & Benefits Employee Flexible Benefits Information/Enrollment link.

Q. Once I submit my claim, when can I expect to receive my money?

If your claim is complete and all required documentation is included, reimbursements are targeted for payment within 30 days following the claim being received by the Risk Management Department. This payment is included on your next paycheck after the claim has been approved.

Q. May I use my Dental/Medical/Vision Reimbursement Account to pay premiums for medical, dental, or other insurance premiums?

No. IRS regulations state other insurance premiums are not eligible expenses.

Q. My child goes to a day-care center while my spouse and I work. Should I set up a Dependent Care Reimbursement Account?

The answer depends on your income. You may also be eligible for the federal tax credit for dependent care, so you must decide whether the tax credit or a Reimbursement Account offers you the maximum tax savings. Refer to pages 31 – 33 for more detailed information.

APPENDIX H

COMPARISONS BETWEEN THE CITY OF SAN DIEGO 401(K) AND DEFERRED COMPENSATION PLANS

	401(K)	DEFERRED COMPENSATION
YOUR DEPOSITS	Use pretax money thru payroll or flex.	Use pretax money thru payroll.
HOW MUCH CAN YOU SAVE	<p>\$16,500 per calendar year. An additional \$5,500 if over age 50.</p> <p>No Three-Year Catchup Provision.</p>	<p>You may contribute up to \$16,500. An additional \$5,500 if over age 50 and not eligible for 3 year catch up.</p> <p>Three-Year Catchup Provision available – prior to the year in which you retire, you can make up for your unused Deferred Compensation contributions for three (3) years (maximum contribution is \$33,000/ calendar year.</p>
PRESENT TAXES ON SAVINGS	No Federal or State Taxes, or most local taxes.	No Federal or State Taxes.
TAXES ON INVESTMENT	Accumulate tax free and paid upon withdrawal.	Accumulate tax free and paid upon withdrawal.
AVAILABILITY OF MONEY WHILE EMPLOYED	<p>Withdrawal permitted for financial hardship only (includes secondary education and purchase of primary residence).</p> <p>Loans available for up to approximately 50% of account balance or \$50,000, whichever is less (minimum loan is \$500).</p>	<p>Withdrawal permitted for financial hardship only.</p> <p>No loan provisions.</p>
TAX TREATMENT WHEN YOU LEAVE YOUR EMPLOYMENT	<p>Rollover available to IRA or other similar plans as defined by the tax code.</p> <p>May be subject to penalty taxes for early withdrawal.</p> <p>May elect to defer distribution to a future payout date, however this date must be before reaching age 70 1/2.</p>	<p>Rollover available to IRA or other similar plans as defined by the tax code.</p> <p>No penalty taxes for early withdrawal unless rolled over into IRA or other similar plan.</p> <p>May elect to defer distribution to a future payout date, however this date must be before reaching age 70 1/2.</p>
ADMINISTRATION AND EXPENSES	Administered by Wachovia. Management fees netted from earnings daily.	Administered by VALIC. Management fees netted from earnings daily.
INVESTMENT OPTIONS	Choice of 14	Choice of 23

APPENDIX I

PROVIDER TELEPHONE NUMBERS

HEALTH INSURANCE

HEALTHNET	1-800-522-0088	www.healthnet.com
KAISER.....	1-800-464-4000	www.kaiserpermanente.org
SHARP	1-800-359-2002	www.sharphealthplan.com

DENTAL INSURANCE

CONCORDIA PLUS DHMO	1-866-215-2358	www.ucci.com
CONCORDIA PREFERRED DPO	1-800-937-6432	www.ucci.com
LOCAL 127 METLIFE/SAFEGUARD DENTAL HMO	1-800-653-7353	www.safeguard.net
LOCAL 127 METLIFE DENTAL DPO	1-800-942-0854	www.metlife.com

VISION INSURANCE

BLUE SHIELD OF CA/MESVISION..... 1-877-601-9083 www.blueshieldca.com

LIFE INSURANCE

ING
Basic & Portable..... 1-800-955-7736 www.ing.com

EMPLOYEE GROUP PLANS

LOCAL 127 (619) 640-4939
MUNICIPAL EMPLOYEES ASSOCIATION BENEFITS (ILS)..... (619) 677-3952 www.sdmea.org

NOTES

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.